DRAFT DOCUMENT

Dear Stakeholder:

The document that follows is the initial draft of the Mental Health Block Grant's State Mental Health Plan for 2007. This plan is required by federal statute each year in order for the state to qualify for block grant funding through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The federal statute requires that public input regarding this plan be solicited. The statute also requires that the state's Mental Health Planning Council participate in the development of the plan and submit a letter commenting upon the plan to the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

The Indiana Mental Health Planning Council will make recommendations for additions/deletions/ and other changes to the plan during the July 21st meeting. The final document will be submitted for federal review at the end of August.

As an individual or group that has an interest in the mental health system in Indiana, you are receiving this document as an opportunity to comment on its contents. Please send your comments by July 19, 2002 to:

Charles Boyle
Charles.Boyle@fssa.in.gov

Fax number: 317-233-3472

Or via mail to:

Charles Boyle
FSSA/Division of Mental Health and Addiction
402 W. Washington St., Room W353
Indianapolis, IN 46204-2739

DRAFT DOCUMENT

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

___FY 2005-2007 ___ FY 2006-2007 _X__ FY 2007

STATE NAME: __INDIANA_____

DUNS #: _196256994_____

I. AGENCY TO RECEIVE GRANT

AGENCY: _Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: __Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

TELEPHONE: 317-232-7866_____ FAX: __317-233-3472_____

II. **OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT**

NAME: _Cathy Boggs_____ TITLE: ___Director_____

AGENCY Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

TELEPHONE: 317-232-7845_____ FAX: __317-233-3472_____

III. STATE FISCAL YEAR

FROM: _July_____ __2006_____ TO: __June_____ ___2007_____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:___Sue Lummus_____ TITLE:__Deputy Director for MH Policy and Planning

AGENCY Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

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DRAFT DOCUMENT

PAGE NUMBERS WILL NEED TO BE UPDATED

Table of Contents

Executive Summary

Indiana has embarked on an initiative to transform the state's mental health and addiction system. A Transformation Work Group (TWG) has been formed for the purpose of achieving: a consumer centric system of planning, service delivery and evaluation, alignment of systems, funding and technology, crafting a state role focused on leadership rather than direct service, using results to inform quality improvement, and knowledge dissemination to move science to service as efficiently as possible.

The Hoosier Assurance Plan, adopted in 1994, continues to be the basis on which the Division of Mental Health and Addiction (DMHA) relates to and funds the Indiana mental health service system. It guides the management of public funds earmarked for mental health services, assuring that priority will be given to individuals in greatest need. Under this plan, DMHA acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and addiction care. The Division has statutory authority for six (6) state-operated facilities, and contracts with thirty-one (31) private not-for-profit community mental health centers and a network of addiction providers.

The Indiana mental health system provides services in all ninety-two counties of the state. The Hoosier Assurance Plan eliminated the traditional geographic service areas. The result has been that consumers have choice of two or more services providers in many areas of the state. This coverage is demonstrated in the tracking of service provided in rural areas of the state that shows an individual living in rural Indiana has the same probability of being served as does someone in urban areas of the state. All providers must provide a Continuum of Care as defined in Indiana Code and by rule. This assures that all individuals served have access to a full array of services ranging from community-based services to inpatient treatment to medication monitoring.

The mental health centers are operating as the gatekeeper for state hospital admissions creating a system in which the community provider continues as an active partner during a state hospitalization and is actively involved in discharge planning and subsequent community care. Each mental health center, through bed allocation, has a limited number of state hospital beds for their use.

The Division has a twelve year history of moving funds from the state operated facility budget to community based services. The Division remains committed to continuation of this dedication to community based services.

Achievements

- Continuation of efforts to promote evidence based practices.
- Provided Wellness Recovery Action Planning (WRAP) for 232 persons; seven Self-Advocacy Skills seminars were held with 106 persons receiving training.
- Continued the growth of ACT to the point where we have 25 of the 31 providers with a certified ACT team.
- Held the third statewide Cultural Competence conference.

- Continue to see increased interest in using Recovery.
- Held the 3rd Annual State Conference on Mental Health and Aging and initiated the Indiana Inter-College Council on Aging.
- Continued statewide mental health screening for all children being placed in substitute care by the child welfare system, and forged a shared data agreement among Medicaid, child welfare and DMHA as a means to evaluate this initiative. This has been presented by DMHA staff at the national Child Welfare League and University of South Florida's Children's Research Institute.
- A broad-based group has studied assessment instruments for children and recommended a tool that can be used across youth-serving systems.
- Have served 43 children through the Home and Community-based waiver.
- Children's Systems of Care are in various stages of development in 63 of Indiana's 92 counties, and served 2% of all children enrolled by service providers.
- Provided the first mental health team through Emergency Management Agreement Compact to respond to Hurricane Katrina; over 40 mental health personnel delivered 11,100 interventions over a six week period in Biloxi, Mississippi.
- SOC Technical Assistance Center named innovative practice in children's mental health workforce development by the Annapolis Coalition.
- Indianapolis Mental Health and Employment Network of Care initiated.
- DMHA staff involved in DOC community corrections application review and asked to serve on Suicide Prevention Summit.
- Consumer training for 2,010 persons.
- Boys-to-Men Mentoring Program held its 3rd Annual Black History Month event.
- Held first National Conference on Dual Diagnosis
- DMHA participated in the NAMI-Indiana Criminal Justice Summit
- Respect Seminar, an educational program by Joel Slack, was presented at two state hospitals.
- DMHA convened a work group to review standardized assessment instruments for adults to be used across all systems; a final recommendation from the work group is anticipated by the Fall 2006.

The Indiana Division of Mental Health and Addiction is proud of the present mental health system and we are excited with the prospect of transforming the system to be a better one.

Federally required forms and Planning Council information to be inserted on pages 5 – 27.

Part C State Plan
SECTION I.
DESCRIPTION OF STATE SERVICE SYSTEM

In October 2005, Indiana embarked on an initiative to transform the state's mental health system. This office sponsored a Transformation kickoff event with a core group of state legislators, agency heads, consumers, family members, providers and researchers. A Transformation Work Group (TWG) of about 45 individuals has been formed for the purpose of achieving: a consumer centric system of planning, service delivery and evaluation, alignment of systems, funding and technology, crafting a state role focused on leadership, not direct service, using results to inform quality improvement, and knowledge dissemination to move science to service as efficiently as possible.

Five committees of the TWG have also been established: Consumer/Family Involvement; Knowledge Dissemination and Use; Results Management; Relationship Management; and Expanded or New Cross-agency Initiatives.

Consumer/Family Involvement will develop a multi-faceted initiative that will ensure that consumers and families are full partners in the development, delivery and evaluation of culturally competent services.
Knowledge Dissemination and Use will develop strategies to address the gap between scientific/best practice knowledge and actual practice.
Results Management will develop measurements for the transformation process; develop measures for performance measures both for the state system and individual providers; and develop measures for service level performance.
Relationship Management will intensify and improve common understandings/metrics/deliverables between DMHA and local providers.
Expanded or New Cross-agency Initiatives will work with a wide range of identified state level agencies to improve and coordinate mental health services.

Each of the committees have been meeting regularly throughout calendar year 2006 and reporting on progress to the TWG. Many transformational ideas are under consideration by the various committees including revisions to the existing statutorily defined continuum of care to include more recovery-oriented services such as Peer Operated Services; changing the methodology by which the mental health and addiction providers access state funds; system accountability through performance (or results) based contracting; ensuring that consumers and family members are full partners in policy, planning, evaluation, and service delivery; and expanding the relationship between policy and research.

As an immediate means to move toward transformation, DMHA instituted the Consumer Services Review process (as a part of the Results Management Committee) which began in May, 2006 and will conclude its initial review process of all 31 CMHC's when 300 cases have been reviewed by the end of 2006. The CSR focuses on practice and results. A sampling of the results are: services in the context of the life of a consumer, understanding of needs and personal recovery goals, responsiveness of the individual

service plan, results and benefits of services for the person; successes and ;missed opportunities. Early results of this new project are seen in the increased request for training in recovery.

The transformation initiative is expected to take several years to fully design and implement. However, some transformational changes will begin to occur over the next fiscal year for implementation by SFY 2008, such as implementation of a new assessment tool for children and performance-based contracts.

Organization of the SMHA

The Division of Mental Health and Addiction is located within a larger agency, Family and Social Services Administration (FSSA). The mission of the Indiana Family and Social Services Administration is *to lead the future of healthcare in Indiana by being the most effective health and human service agency in the Nation.* The FSSA includes the Division of Aging, Office of Medicaid Policy and Planning, Division of Disability and Rehabilitative Services, Division of Family Resources and the Division of Mental Health and Addiction. The divisions report to the FSSA Secretary, who is a member of the Governor's cabinet.

The Division of Mental Health and Addiction is actively involved with the Department of Correction (DOC) in expanding Community Correction programs to include children's Systems of Care and a variety of adult treatment programs. The Division and DOC have begun collaborations with adult and juvenile community re-entry programs. Two people from DMHA were asked to participate in DOC community corrections grant reviews in 2006. As a result of this participation DMHA offered to assist the community corrections agencies in improving their relationship with the local mental health providers. Our participation in these reviews was positively received by DOC and it improved our understanding of community corrections.

DMHA has developed extensive collaborations with the Department of Child Services (DCS). (The Department of Child Services was created as an independent state agency by the Indiana General Assembly during the regular legislative session of 2005. Previously child services had been part of FSSA.) For the past two years, DMHA and DCS, along with Medicaid, juvenile justice, and Department of Education, have developed the Early Identification and Intervention Initiative to screen all children entering the child welfare system. A major outgrowth of this collaboration is the selection of a specific assessment tool, the Child and Adolescent Needs and Strengths (CANS), to be used across all child-serving agencies. The Department of Correction plans to initiate its use of the CANS in October 2006, while DMHA plans to implement it in July 2007. The product will be an outcome quality management process which will inform treatment, level of care decisions, and identify successes and gaps within systems. A similar process is being considered across systems serving adults. Additionally, DMHA partners with DCS in the targeted capacity methamphetamine grant in developing adult treatment resources.

DMHA is a "core partner" with the Indiana State Department of Health (ISDH) in planning for a more comprehensive early childhood system. In this process state agencies, community partners and families collaborate to develop a strategic plan leading to a coordinated, comprehensive, community-based system of service for young children. This process is supported by a planning grant from the Federal Maternal and Child Health Bureau. DMHA shares joint ventures with ISDH in suicide prevention and disaster management planning. Mental health services are included in the ISDH annual budget. Through this joint venture Indiana was the first mental health team to be deployed through an Emergency Management Agency Compact (EMAC) Order following Hurricane Katrina. DMHA furnishes prenatal substance abuse education through ISDH programs. The state survey of mental health professionals is a cooperative venture with ISDH.

FSSA/DMHA partners with many institutions of higher education. Of significance, in March 2006, DMHA and the Indiana University School of Medicine jointly sponsored a national conference on Co-Occurring Disorders in Indianapolis. The purpose of the conference was to exchange and disseminate scientific information on the neuroscience, clinical phenomenology, and societal impact of substance use disorders in persons with mental illness, providing an intensive and comprehensive examination of the issue of co-occurring substance use disorders and mental illness. Attending the conference were physicians and other clinicians who work in addictions and mental health treatment settings. One-hundred and twenty physicians attended.

For several years this office has worked with and supported the Indiana Mental Health Research Consortium at Indiana University. This is a group of researchers, DMHA staff, family members and consumers that select topical issues for further research. We also fund extensive medical research at the Indiana University School of Medicine. There are two technical assistance projects; one for children’s SOC and one for adult EBP’s located at Indiana University and at Indiana University-Purdue University at Indianapolis. There is a data collection and research project that is at Ball State University that receives funds from this office. We have a good and long standing relationship with several universities.

DMHA is represented on the Governor's Interagency Coordinating Council on Infants and Toddlers, First Steps state panel and Head Start state panel, the Drug Endangered Child Task Force, Transitioning Youth Planning Group (Department of Education, Vocational Rehabilitation, and Department of Workforce Development) DMHA is represented on the state Advisory Council that is charged with developing Indiana's IDE IA, as well as the state's newly formed Student Assistance Program Advisory.

The 2005 state legislature ordered the development of a Comprehensive Children's Social, Emotional and Behavioral Health Plan for children 0-22. A workgroup, lead by the Department of Education, included all Indiana child serving agencies and family representatives was tasked to develop the plan, which went to the state Board of Education for review and for consideration by the state legislature.

The Division is represented on the Interagency Council on Homelessness and has been actively involved in the preparation of the Indiana plan to end chronic homelessness. The Division is also represented on the Indiana Low Income Housing Trust Fund Advisory Committee.

Description of the State Mental Health System

The Division of Mental Health and Addiction (DMHA) contracts with privately owned, not-for-profit mental health centers for the provision of care. The guiding plan for mental health services is the Hoosier Assurance Plan (HAP) as developed following mental health reform legislation in 1994. That reform and the resultant HAP substantially changed the relationship DMHA has with the provider system. The DMHA funding system is a payment system based on enrollment of and services for a targeted population: those with a SED or SMI at or below 200% of poverty. This focuses our funding on the poor and enables DMHA to assure that treatment funds are used for the neediest population.

The contracted providers have over 200 service sites throughout the state. We are very proud to say that the penetration rates in rural Indiana are equal to the penetration rates in urban Indiana.

The HAP eliminated the traditional catchment areas and encouraged the development of multiple service providers in many areas. This has produced more consumer choice as there is more than one provider from which to choose in many areas of the state. In some of the more populated areas of the state there are four or more providers from which to choose.

Indiana providers are required by law and by contract to provide a Continuum of Care that delineates the full array of services that are to be available to everyone enrolled in treatment services. The Continuum of Care has been further defined in certification rules. The Continuum of Care will be discussed in more detail in both the adult and children's Section II. Case management, a required part of the continuum of care is also defined in Indiana Code and further regulated by rule. This will also be further discussed in Section II.

The DMHA instituted a gatekeeper practice wherein the mental health centers are responsible for an individual's entry into and exit from a State Psychiatric Hospital. The referring mental health center is required to participate in the treatment planning and discharge planning for persons admitted to a State Psychiatric Hospital from the community. This has created a system in which people referred to a state facility are not placed and forgotten. This has also created a closer tie between the state hospital and the mental health centers. A children/youth Level of Care application was adopted in 2003 to assist children's gatekeepers in determining if sufficient community-based interventions had been tried before hospitalization.

This office has assigned to each provider a number of State Hospital beds that they can use. The allocation is based on the population in need of services in an area. This has

created a system where each provider has a limited number of beds to use and eliminates the overuse by any one provider. We presently have 690 state hospital beds allocated to the community mental health centers. The number of beds is not static since the availability of beds is influenced by the number of admissions that are not under the control of the mental health centers such as outdates from corrections, forensic admissions, and admissions of persons with mental retardation/developmental disabilities from other state institutions that are being closed.

The development of Children's Systems of Care has been seeded by state funding since 2000, and approximately 66% of the state now has some level of system of care development in place. Indiana is home to 2 federally funded Systems of Care sites; the Dawn project in Marion County and Circle Around Families in Lake County, both successfully completed their final grant-funded years. During SFY 2006 over 1,000 children/youth and their families were served by Systems of Care. The state-funded Technical Assistance Center for Systems of Care and Evidence-based Practices supports the movement through coaching, training, assessment and dissemination of the theory of change.

The DMHA Office of Emergency Management and Preparedness coordinates with the Indiana Department of Homeland Security in developing a behavioral plan to work with first responders and to offer psychological services for those impacted by disasters.. In collaboration with the Indiana State Department of Health training of behavioral health teams are being conducted so that each region of the state will be covered for disaster response. Additionally, a state level team of 75 clinicians has been trained so they can be promptly deployed. The Governor recently convened an Indiana Pandemic Summit which included mental health issues surrounding a pandemic. The Office is working with Developmental Disabilities agencies interested in disaster mental health services. DMHA has been asked to participate in a newly created DMORT Team (Disaster Mortuary Team) DMHA is collaborating in the development of online training through the Learning Management System from the University of Illinois.

DMHA has made it a priority to have the mental health and addiction providers address cultural competency within their agencies to improve treatment outcomes of persons from various cultures and groups. The providers throughout the State have participated in the Cultural Competency Training Project that has been offered via contract with an training organization. The Division of Mental Health and Addiction is in the process of developing a racial/ethnic profile of Indiana’s mental health and addiction provider organizations. The profile will allow our division to identify how provider are addressing cultural competency. The racial/ethnic profile and the cultural competency information will also aid DMHA in securing future funding as well as meeting data requirements for current funding streams. A survey was developed and sent out to our mental health and addiction providers to capture this information (See Survey Attached). Internally, DMHA’s Cultural Competency committee continues to facilitate the diversity and cultural efforts within the agency. The group’s goal is to be the mechanism for institutionalized diversity within DMHA. Cultural Competency Committee area of focus

include: Recruitment; Education; Retention; Mentoring; Training; and Staff Cultural Activities (Programs, Pitch-In, etc.).

During SFY 2006, 250 persons received cultural competence training. An additional 175 persons participated in DMHA's 6th Annual Indiana Conference on Cultural Competency for Behavioral Healthcare entitled "OUR CULTURAL CONNECTIONS'.

DMHA has established partnerships with the faith-based community throughout Indiana. The purpose of this initiative is to educate and train faith-based organizations on identifying mental health and substance abuse illnesses. These faith-based organizations are also provided with information about referral processes once an individual has been identified as needing mental health or addiction services. Indiana, also host the nationally noted Black Expo Summer Celebration event in which our agency, through FSSA, play a major role in planning of the Youth Summit. We assist in the coordination of this event where many of the youth from State assisted services throughout Indiana come to Indianapolis to participate in the Summit. The Summit Goals include:

*Prepare youth for their academic, personal and community service goal achievements.
*Assist youth in developing leadership skills to better their communities.
* Provide training to youth service workers to better assist youth.

Over 400 youth, ages 11 to 18 participate in this event. The division also coordinates a annual HIV Statewide Awareness Program. The goal of this program is to educate and increase awareness among individuals, families, groups, organizations, providers, advocates, and concerned citizens across the State of Indiana about Prevention and Early detection of HIV. The Bureau of Critical Populations spearheads the annual event. Last year's keynote speaker, Hollywood actress Regina King, spoke about Hoosiers answering the call to action and take responsibility for the prevention HIV in their own communities.

In order to assure Cultural competent mental health and addiction services for persons who are deaf or hard of hearing, DMHA contracts with three (3) providers in Indiana for specialized services for this population. These providers maintain staff who are deaf or hard of hearing and are knowledgeable about the cultural aspects of hearing loss and who are trained mental health and/or addiction professionals.

DMHA has established partnerships with local and state faith based organizations in order to promote interconnectivity between the mental health and addiction system and these organizations that have extensive contact with consumers. The partnerships have several goals including identification of mental illness and addiction, dissemination of information regarding referral procedures, increasing awareness of appropriate treatments, and encouraging greater levels of collaboration and consultation. The first, highly successfully "Faith Healing and Hope" Conference was held, to celebrate treatment and recovery and had 275 persons attending. The newly established Governor's Office of Faith and Community-based Initiatives further supports the role of cultural competence.

We closed a state hospital in 1994 and that budget was moved to community based services. Since that time we have closed the equivalent of another state hospital by downsizing the remaining institutions. The funds realized by that downsizing have been moved to community services as well.

During the past year we sought applications for private operation of one state hospital. There was one response to that announcement and we are presently in negotiations to finalize that move to private operation.

The Community Services Data System was instituted in 2001. This is a consumer based data system that collects detailed demographics and diagnostic information from all treatment providers. It also tracks treatment encounters over the course of treatment for each individual served by the funded providers in Indiana. It has greatly increased our understanding of the services provided and has made it possible to comply with the Mental Health Block Grant requirements for data collection.

The DMHA Planning Council voted to begin meeting on a bi-monthly basis in order to allow time for discussion. Revisions to the By-Laws are under consideration to address the role of Planning Council leadership. The Consumer subcommittee continues to have three meetings per year in addition to the planning council meetings. The Consumer Council has developed a position paper regarding Recovery, which is being shared with the Transformation Work Group.

We continue to see increases in our involvement in Evidence Based Practices especially Assertive Community Treatment, Illness Management and Recovery and Integrated Dual Diagnosis Treatment. There are twenty agencies that are funded ACT pilot sites and an additional three agencies have added ACT without special funding. The Indiana Medicaid rule was changed to include a daily rate for ACT. The Division expects continued growth in the area of ACT as more programs begin or expand the number of ACT teams. There are seven pilots involved in IDDT. We will be implementing IMR at six pilot sites over a two year period under a SAMHSA grant.

There are a limited number of Evidence Based Practices for children. Researchers consistently describe Systems of Care as a promising practice. The Systems of Care Technical Assistance Center has begun work with Indiana's system of care sites to help them define their practice model and to subsequently develop fidelity practices. Measurement of fidelity will be accomplished through use of the Wraparound Fidelity Index. Information from the fidelity measurements will then be utilized for system improvement. As fidelity and outcome data are collected on a wide variety of services delivered throughout Indiana, effective models of care will emerge. These models can then be shared and implemented in other communities.

Supported employment has been in existence for almost twelve years in Indiana. At this time there are 27 mental health centers that provide supported employment. Changes in the client based data system (CSDS) beginning in state fiscal year 2006 will create a better focus on supported employment and employment outcomes as the result of

employment programs. Additionally, the Office of Vocational Rehabilitation, which is within the FSSA Division of Disability and Rehabilitative Services, is taking an in-depth look at employment outcomes for all agencies involved in supported employment.

Indiana was awarded a Pilot 1915(c) Home and Community-based Medicaid Waiver in 2004 for children with serious emotional disorders. The waiver provides a community-based option for children who are eligible for state hospital admission.

Data section

Indiana's 1994 Mental Health and Addictions Reform Law required the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) to purchase community-based care for children and adolescents with serious emotional disturbance (SED), adults with serious mental illness (SMI), and persons of all ages with chronic addictive disorders (CA). These broad changes resulted in new DMHA information technology.

On July 1, 2000, the second generation, web-based Community Services Data System (CSDS) went live. This system is primarily a data collection system, developed in part with SAMHSA CMHS State Reform Grant dollars.

The infrastructure goal for the Indiana DMHA since SFY2001 has been to build upon the existing DMHA technology framework to develop an integrated, sustainable system (the DMHA Data Mart) and a Cognos software based, user-friendly reporting tool (the DMHA Reporting System, or "DRS"). This new technology is intended to be used to satisfy all SAMHSA data requirements, from block grants to discretionary grants to agreements such as DASIS TEDS. Federal discretionary dollars have allowed the Indiana DMHA to achieve these technology goal in ways that not only met the federal reporting requirements, but that also greatly improved Indiana DMHA's ability to integrate and report data. The SAMHSA grants and agreements used to support the development of the DMHA Data Mart and the DMHA Reporting System (DRS) include:

- SAMHSA OAS DASIS TEDS
- SAMHSA CMHS State Reform Grant, 16 State Project Grant, and DIG I & DIG II infrastructure technology grants
- SAMHSA CSAT State Data Infrastructure (SDI) Grant and State Treatment Needs Assessment Program (STNAP) Grant

The Indiana DMHA can now utilize data from DMHAs two major data collection systems, as well as from other data sources, relieving data bottlenecks, and allowing the dissemination of DMHA information to a wide audience.

Throughout this technology development, the Indian DMHA learned a great deal about data quality and integrity; data and reporting standardization; the roles of technical personnel; technical project management; technology business rules; data and reporting structure, processes, and procedures; electronic data archiving; project collaboration; and much more. State personnel were able to upgrade skill sets with much-needed software training and were able to gain access to DMHA's data. Reports were and continue to be

disseminated via the DMHA public website and new initiatives to support provider data and reporting needs are occurring.

During SFY 2006, the data section met with the Mental Health Planning Council on two occasions to present information on the data collected by DMHA and the ease in generating reports from that data. This was done so the planning council would have a better understanding of the power of the data and recommend/request reports that can assist in fulfilling their planning and advisory role. Future plans include ensuring data is available to the members of the planning council throughout the year as they deliberate issues related to the current state of the mental health system and formulate recommendations for change.

SECTION II (ADULTS)
IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEMS STRENGTHS, NEEDS, AND PRIORITIES

Criterion 1
Comprehensive Community Based Mental Health System

Organizational structure of the system of care

Indiana provides a statewide mental health service system by contracting with thirty-one privately held not-for-profit community mental health centers that provide a full continuum of care in all areas of the State. There are over 200 service sites throughout the state providing services in each of the 92 counties in the state.

The 1991 Mental Health Reform Legislation the Division of Mental Health and Addiction (DMHA) lead to the creation of the Hoosier Assurance Plan (HAP) that initiated several changes in the mental health system. The major changes were: the elimination of traditional service areas; creation of the Gatekeeper rule; implementation of a bed allocation system; payments based on enrollments; and service responsibility.

Elimination of traditional service areas. Prior to HAP, the CMHC's served people living within catchment areas. People living within those areas qualified for reduced or subsidized treatment costs, those that wanted treatment outside of the catchment area did not qualify for the reduced fees and had to pay full treatment costs. The elimination of catchment areas created consumer choice of providers. There are now several areas in the state where there are multiple providers offering services.

Gatekeeper rule. DMHA developed a gatekeeper rule governing admission to and discharge from a state operated facility. This defines the relationship between the state operated hospital system and the state supported community mental health center system. The thirty-one community mental health centers are required to serve as the gatekeepers for State Hospital admissions and discharges and the admitting mental health center is required, by rule, to be involved in the treatment of an individual during hospitalization and to participate in the discharge planning. We formalized the gatekeeper role by promulgating a rule that defines, in administrative code, the responsibilities of the gatekeeper. Each mental health center has a SOF liaison that is responsible for assuring that the community provider and the state operated facility are working together on treatment and discharge planning. The mental health centers and the State Hospitals are acting as a team to focus on the return of individuals to the community.

Bed allocation. Through a bed allocation process, DMHA assigns to each mental health center the number of state hospital beds they will be able to use during a fiscal year. This allocation is based on the population base of the provider and the number of persons served in the previous year. This has leveled the use of the state hospital beds by the providers.

Service responsibility. When a provider enrolls a HAP eligible individual in services that provider is assuring that they will provide services for the fiscal year. We are tracking the level of services provided to individuals that are enrolled.

The CMHC's are required by Indiana Code (IC 12-7-40.6) and by contract to provide a defined Continuum of Care. Continuum of care means a range of services, the provision of which is assured by a community mental health center or a managed care provider. The term includes the following:

1. Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section.
2. Twenty-four (24) hour a day crisis intervention.
3. Case management to fulfill individual patient needs, including assertive case management when indicated.
4. Outpatient services, including intensive outpatient services, substance abuse services, and treatment.
5. Acute stabilization services including detoxification services.
6. Residential services.
7. Day treatment.
8. Family support.
9. Medication evaluation and monitoring.
10. Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

In addition to the Continuum of Care, Community Support Services are a mandated service. Community Support Services require coordinated case management services, outreach, assessment and diagnosis, crisis intervention, psychiatric treatment including medication intervention and supervision, counseling and psychotherapy, activities in daily living training, psychosocial rehabilitation services, client advocacy, residential services, recreational activities, vocational services, and educational services. Community Support Services are also responsible for the admission and discharge planning of persons entering and returning from the state hospitals.

Evidence Based Practices

In 1999, DMHA decided to promote the development of Assertive Community Treatment. To assist in developing ACT, DMHA sought out the assistance of Dr. Gary Bond. We funded the ACT Technical Assistance Center headed by Dr. Bond at Indiana University Purdue University at Indianapolis. The Center provides regional training events, maintains a web site, publishes an ACT newsletter, provides job shadowing, and generally works with and assists the development of the ACT model.

In 2000, this office standardized Assertive Community Treatment (ACT) in the state. We defined Assertive Community Treatment in Indiana and we have promulgated the ACT rule. This process started with a meeting of the researchers with Dr. Bond's team, DMHA staff, providers, consumers and family members. The framework for the present rule was established through a series of meetings with this group.

Through funding a series of ACT pilot sites, we have 20 funded sites along with five other centers that decided to develop ACT teams without funding. There are a total of 30 ACT teams located at 25 centers.

As of June 2004, ACT has been added to the State Medicaid Plan. An ACT policy and daily rate have been implemented.

There are six pilot sites participating in the Dartmouth Integrated Dual Diagnosis Treatment (IDDT) tool kit. The ACT Center is providing the training and monitoring of these projects. There are several other centers that are moving to IDDT. One CMHC has opted to implement IDDT center wide with good results. The DMHA has created a funding category for the dually diagnosed. This office also participated in the XXX to create a plan for XXX.

DMHA, in conjunction with the ACT Center, was successful in securing a SAMHSA grant to develop Illness Management and Recovery (IMR) at six sites. The second year application has been funded. The ACT Center is providing the training and monitoring of this project. There is growing interest in recovery across the state.

Supported Employment (SE) has been in operation in Indiana for twelve years. Not all of the SE programs are adhering to the EBP model but there are plans to change the teams. SE is discussed more fully later in this section.

The Indiana NAMI has been providing the Family to Family education series for several years. This is considered as part of the EBP Family Psycho-Education. This effort, funded by DMHA, is considered a move toward implementing the evidence-based practice.

Beginning in state fiscal year 2006, information at the individual consumer level is being reported for IDDT, IMR, and Supported Employment by the mental health centers. This data collection is in addition to previously collected information regarding ACT services. Family Psycho-Education data is not collected since the NAMI program is not individual consumer specific

This office is very pleased that we are offering four of the six EPB's for adults. ACT is adequately funded and defined by rule. IDDT has a funding source but is not defined by rule. Supported Employment is funded by the Office of Vocational Rehabilitation and the SE programs are required to have national accreditation, however there is no requirement that the SE programs use the EBP model. IMR is not funded nor is it defined in rule.

Available system of treatment, rehabilitation, and support services

All community providers are involved in rehabilitation and employment. Those with supported employment programs are more formally involved in the provision of employment services.

In 1994 the closure of a state hospital made available state funds that were dedicated to additional community based services. The DMHA and the Office of Vocational Rehabilitation (OVR) established a series of grants using a portion of those SOF funds to create supported employment programs. This office was able to use the new state funds as match for federal funds available to OVR. That started a series of establishment grant that was used to develop supported employment at mental health centers.

As we began the establishment grants, we used the same funding arrangement with OVR to fund the Supported Employment Consultation and Training Center (SECT) at the Center for Mental Health, Inc. in Anderson, Indiana. The SECT center is a provider of technical assistance to providers interested in developing or improving supported employment efforts. They continue to be very active in providing training to the newly funded supported employment projects. One added component of the grant is data collection. This consists of collecting information on the numbers of persons entering supported employment, their wages, the cost of supported employment counseling, the average time worked, the average wage, benefits and many other areas.

At this time we have 28 mental health centers that are providing supported employment under a contract with OVR. The ACT certification rule mandates that there be a supported employment program present and that there be an employment specialist on the ACT team.

In 2001, legislation was enacted that changed the Indiana Medicaid rules to allow for a Medicaid buy-in program. This program called MEDWorks enables persons with a disability to continue Medicaid coverage by paying a premium to Medicaid based on their monthly income to help offset the cost of the program. People on Medicaid no longer need fear loss of Medicaid and many now working at lower pay levels are able to accept a pay increase, promotions and additional hours.

For several years DMHA has been working with a committee that is exploring supported education. That effort lags behind the supported employment success but surveys of consumers, providers and educators indicate there is potential for expansion in this area. The OVR continues interest in this project and has been involved in the committee work. A recent analysis of persons between the ages of 14 and 30 who are receiving public mental health and addiction services in Indiana revealed that two issues significantly separate these individuals from the general population within the same age range. These two issues are education and employment, both of which have significantly lower rates for persons being served in the public system. This analysis supports the need to emphasize implementation of and continuation of Supported Education and Support Employment programs.

During the past year this office has been involved with an exciting work group. The mayor of Indianapolis and the president of Eli Lilly decided that they needed to examine employment of persons with mental illness. There is now a work group with about 40 individuals involved in employment programs examining the barriers to employment. One of the projects that came from this work group is pilot projects in which OVR will provide staff one day a week to be located within a CMHC to do interviews and

authorizations for services. This will eliminate the need for the individual to make an appointment at an OVR office and will increase the number and speed of authorizations. As Lilly becomes more involved in this project and becomes more supportive of employment programs it is expected that there will be an affect on all supported employment programs in the state as employers in Indiana tend to pay attention to what Lilly does.

Description and definition of case management system

Case management services are goal oriented activities that assist individuals by locating, coordinating and monitoring necessary care and services appropriate and accessible to the recipient. The major components of service are essential to reducing the impact of handicaps or disabilities experienced by the person served. This service is to be available 24 hours per day, seven days per week. Any individual who meets the definition of having a serious mental illness is eligible for case management.

Indiana Code defines case management services in Chapter 19. "Community Care for Individuals with Mental Illness".
"Sec. 2. (a) As used in this chapter, "case management" means goal oriented activities that locate, facilitate, provide access to, coordinate, or monitor the full range of basic human needs, treatment and service for individual patients.
(b) The term includes where necessary and appropriate for the patient the following:
(1) Assessment of the consumer.
(2) Treatment planning.
(3) Crisis assistance.
(4) Providing access to and training the patients to utilize basic community resources.
(5) Assistance in daily living.
(6) Assistance for the patient to obtain services necessary for meeting basic human needs.
(7) Monitoring of the overall service delivery.
(8) Assistance in obtaining the following:
    (A) Rehabilitation services and vocational opportunities.
    (B) Respite Care.
    (C) Transportation.
    (D) Education Services.
    (E) Health supplies and prescriptions."

We have also established a rule for the provision of case management. That rule covers in detail the minimal standards for the provision of case management by the mental health centers. The rule is inclusive of the mandates of the above law and provides more measurable components and eliminates much of the areas that were open to interpretation under the law alone.

Historical reduction of state hospital beds and changes in utilization of psychiatric inpatient in other settings

As mentioned above, this office closed a state hospital located in 1994. The state funds used to operate that institution were moved to support community based services. To evaluate the effects of this closure, this office funded research over ten years to track all of the individuals who were at that hospital at the time of the closure. This research measured many quality of life issues and the researchers maintained contact with nearly all of 400 individuals present at the hospital closing. In addition, the research tracked former employees of the hospital to examine the effect of the closure on them. There have been regular reports by the researchers including annual reports on the data collected. A series of articles based on the data collected appeared in *The Journal of Behavioral Health Services & Research*, August 1999, Volume 26/Number 3. This research project is now completed and we have the final reports from the researchers.

Description of Substance Abuse Services for Adults with Serious Mental Illness

All mental health centers in Indiana provide substance abuse services. However, not all have developed integrated programs for the person with SMI who is also using substances. A survey of providers indicated that 14 of the 30 providers have an identifiable dual diagnosis track for consumers.

Indiana is involved in the Dartmouth Dual Diagnosis tool kit project. We are working with the Technical Assistance Center at Indiana-Purdue University at Indianapolis on this project. Six mental health centers have agreed to be part of the project and will be establishing integrated services for the dually diagnosed according to the tool kit. We have created an enrollment category for dual diagnosis. One CMHC has opted to use the IDDT model throughout their center rather than providing a single IDDT project.

Housing

The mental health centers, as a requirement of the Continuum of Care, are responsible for residential services. Some have been very active in securing HUD financial assistance to develop a range of residential options. Seven have been awarded Shelter Plus Care grants. This office has had a number of events to encourage the providers to be better able to seek funding. We have taken steps to insure that providers participated in the Consolidated Plan and in the Continuum of Care application.

Housing continues to be a major concern for all providers. This office has a maintained a relationship with HUD, the Indiana Housing and Community Development Agency, and we continue to link our providers with funding information. In July this office met with HUD to discuss the need for additional housing.

Medical and Dental services

Mental health centers are required by rule to complete a physical health screen with referral for a physical examination when clinically indicated. Additionally, in the normal course of treatment the consumer often asks for assistance in securing any medical or

dental assistance. For residential care, the rule states that the provider must assist the resident to obtain medial and dental care.

Office of Family and Consumer Affairs

In the amendment of the 2000 Block Grant Plan this office decided to use the increase in Block Grant funds to establish an office of consumer affairs. That position remains and has proven to be an asset to this office. The purpose of the Office of Consumer and Family Affairs is to empower consumers and family members by assuring their interests are represented and their input is considered in DMHA planning and policy development.

The Office of Consumer and Family Affairs for the coming year are:

- This bureau is advocating for DMHA funding to support peer provided services to families of children with SED, and adults with SMI and / or CA.
- The Bureau Chief served on the planning committees of the CMHS Joint National Conference of the Mental Health Block Grant and the CMHS national consumer conference, Alternatives 2006.
- The Division of Mental Health and Addiction sent a team to the NASMHPD National Executive Training Institute: Creating Violence Free and Coercion Free Mental Health Treatment Environments / A National Initiative toward Culture Change and Transformation
- With funding under the Olmstead mental health grant, sixteen consumers attended the third Indiana Leadership Academy; eight Self-advocacy and Rights seminars were held with 115 persons trained; twenty-nine Wellness Recovery Action Planning (WRAP) training seminars were held with 720 persons trained. The film *Inside / Outside, Building a Meaningful Life Outside of the Hospital* was shown to 75 consumers at Madison state hospital. Indianapolis Thresholds Project Leadership training, sponsored by HUD, Dept. of Labor, and the Corporation for Supported Housing was held for 26 participants. Total 936 persons trained.
- Obtained advanced training for three individuals in Wellness Recovery Action Planning (WRAP).

Services for the Elderly

3rd Annual State Mental Health and Aging Conference. Planning is underway for the 3rd Annual State Mental Health and Aging Conference. The conference is co-sponsored by DMHA, the State Unit on Aging, the Indiana Coalition on Mental Health and Aging, and the Indiana Inter-College Council on the Aging and in cooperation with many others. The Older Persons Division of the National Association of State Mental Health Program Directors will hold their annual meeting concurrently with the State Conference. This collaboration has made it possible to involve many nationally recognized leaders in the field including representatives from federal agencies such as SAMHSA and CMS. Sessions are planned on addressing the needs of minority older adults, evidence-based

practices, dealing with problem behaviors of older adults with mental illness and/or dementia, seclusion and restraint, federal initiatives, PASRR, and the mental health outcomes of the White House Conference on Aging.

Indiana Inter-college Council on Aging. DMHA continued to work closely with the Indiana Inter-College Council on Aging. The Division took the lead in organizing the Council in 2004. A DMHA staff member served as interim chair during the organizational phase and remains on the executive committee. The purpose of the Council is to provide leadership and foster collaboration in gerontology research and education. The group started with the focus being on older adult mental health and substance abuse, but expanded its mission to include the broader range of aging. All of the major universities in the State, including Indiana, Purdue, Ball State, Notre Dame, Butler and Indiana University – Purdue University Indianapolis (IUPUI) are active members of the Council. The current chair is from the University of Indianapolis, who also hosts the meetings. Earlier this year members of the Council served on the planning committee and were local hosts for the Association of Gerontology in Higher Education (AGHE) annual national meeting held in Indianapolis.

Older Adult Specialists at community mental health centers. For many years the DMHA has required community mental health centers to provide older adult services, to designate a contact person for older adult services, and to provide the federally mandated PASRR program. The Division works with the Older Adult Services Committee of the Indiana Council of Community Mental Health Centers to provide training conferences annually. The designated staff members will be invited to participate in the State Mental Health and Aging Conference and have been offered the opportunity to meet concurrently with the Conference. The Division obtained and distributed copies of the *Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources.* This Tool Kit was developed by the National Council on the Aging through a SAMHSA grant. A DMHA staff member participated in the development of the Tool Kit and several Indiana programs are highlighted in the materials.

Indiana PASRR program. Indiana has used the federally mandated PASRR program as an opportunity to identify nursing home residents with mental illness and to assist the residents in accessing services. DMHA works in partnership with the State offices for aging, health, and Medicaid to administer the program and to assure that nursing homes are following-up on PASRR service recommendations and are providing or arranging for services to meet the mental health needs of the residents. Indiana's program is viewed as a model and other states are frequently referred to Indiana by the Centers for Medicare and Medicaid Services for consultation and technical assistance. A DMHA staff member represents state mental health agencies on a CMS expert panel assessing the PASRR program. He has been invited to present on PASRR at several past and future conferences.

White House Conference on Aging (WHCoA). A DMHA staff member was a congressionally appointed Delegate to the 2005 White House Conference on Aging. Realizing that mental health had received little attention at previous White House

Conference's he worked collaboratively with the National Coalition on Mental Health and Aging, many other national organizations, and state and local coalitions to assure that it was fully on the agenda at the 2005 WHCoA. The effort was highly successful with mental health being voted the #8 resolution overall and being reported in the Washington Post as one of the top 3 issues emerging from the Conference. Efforts will be devoted in the coming year to support the implementation strategies contained in the WHCoA Final Report.

Olmstead publication. A DMHA staff member co-edited and co-authored *Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities* which was published by SAMHSA in late 2005. Dissemination presentations have been made on this at several national conferences and will be presented at the 2006 SAMHSA/CMS Invitational Conference on Medicaid and Mental Health Services/Substance Abuse Treatment later this year.

Mental Health Transformation

In Oct., 2005, Indiana embarked on a movement to transform the state's mental health system. This office sponsored a day long Transformation kickoff event with a core group of state legislators, agency heads, consumers, family members, providers and researchers. A smaller but similar group formed the Transformation Workgroup for the purpose of achieving: a consumer centric system of planning, delivery and evaluation, alignment of systems, services, funding and technology, crafting a state role focused on leadership, not direct service, using results to inform quality improvement, knowledge dissemination to move science to service as efficiently as possible.

Five work groups were developed: Consumer/Family Involvement; Knowledge Dissemination and Use; Results Management; Relationship Management; and Expanded or New Cross-agency Initiatives.

Consumer/Family Involvement will develop a multi-faceted initiative that will ensure that consumers and families are full partners in the development, delivery and evaluation of culturally competent services.
Knowledge Dissemination and Use will develop strategies to address the gap between scientific/best practice knowledge and actual practice.
Results Management will develop measurements for the transformation process; develop measures for performance measures both for the state system and individual providers; and develop measures for service level performance.
Relationship Management will intensify and improve common understandings/metrics/deliverables between DMHA and local providers.
Expanded or New Cross-agency Initiatives will work with a wide range of identified state level agencies to improve and coordinate mental health services.

As an immediate means to move toward transformation, DMHA instituted the **Consumer Services Review** process which began in May, 2006 and will conclude its initial review process of all 31 CMHC's when 300 cases have been reviewed by the end of 2006. The CSR focuses on practice and results. A sampling of the results are: services in the

context of the life of a consumer, understanding of needs and personal recovery goals, responsiveness of the individual service plan, results and benefits of services for the person; successes and ;missed opportunities. Early results of this new project are seen in the increased request for training in recovery.

Strengths and Weaknesses of the Indiana Adult Mental Health System

Strengths:

- Mental health services are available in all 92 counties.
- We have a defined and required Continuum of Care and Case Management that provides the base of services for all mental health services.
- We instituted an Office of Consumer Affairs that continues to be a benefit to this office and the consumers in Indiana.
- There is a strong dedication to Evidence Base Practices as shown by our involvement in four EBP's.
- We have a strong history of supported employment with most of the providers participating in the model.
- The gatekeeper model and bed allocation have placed the mental health centers in a position where they are active participants in a persons stay in a state facility.
- Dedication to transformation

Weaknesses:

- We do not have strategy to fiscally continue EBP's and we are working to develop policies that will help offset that.
- "Outside" (primarily forensic and developmental disability) admissions to the state facilities are limiting the number of beds available to the community provider.
- Employment rates remain low for persons with serious mental illness

Criterion 2
Estimations of Prevalence and Mental Health Systems Data

Quantitative population targets to be achieved through implementation of the mental health system including estimates of numbers of individuals with SMI in the state and the numbers of such individuals served.

State Definition of SMI

Indiana Administrative Code (440 IAC 8-2-2) provides the definition of adults with serious mental illness as follows:

A) The individual is eighteen (18) years of age or older.
B) The individual has a mental illness diagnosed under the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.
C) The individual experiences significant functional impairment in two (2) of the following areas:
    i) Activities of daily living
    ii) Interpersonal functioning
    iii) Concentration, persistence, and pace
    iv) Adaptation to change
D) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.

This definition closely parallels the federal definition of serious mental illness and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of adults with Serious Mental Illness in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level.

Center for Mental Health Services Methodology — Based on the *Federal Register* "final notice" of June 24, 1999: Estimation Methodology for Adults with Serious Mental Illness (SMI), the prevalence for Indiana adults with Serious Mental Illness is over 250,000 persons (see table below).

Population Prevalence Estimates at 200% FPL — The 2005 total number of adults aged 18 and above in Indiana based on projections from the 2000 census will be approximately 4,648,737. Also based on the 2000 United States Census reports, approximately 26% of Indiana's adult population has incomes at or below 200% of the federal poverty level.

The following table depicts the prevalence of adults with mental illness in Indiana based on the two estimation methodologies.

INDIANA ADULTS WITH SERIOUS MENTAL ILLNESS

Eligible for DMHA Services	66,129
CMHS Estimation Methodology	251,032
2005 Indiana Population aged 18 and above	4,648,737

Strengths:

- There have been steady increases in the numbers of persons served each year so that we have increasingly larger penetration rates.

Weaknesses:

- There has been no proportional increase in funding in response to the increased number of persons served.

Criterion 4
Targeted Services to Homeless Populations
Targeted Services to Rural Populations

Description of the homeless population

According to the Indiana Continuum of Care, there are 58,000 homeless in Indiana in a year's time. Of these, it is estimated that one third or 19,000 homeless individuals have a mental illness.

Description of available services

The client based data collection provides information on living situation that includes homelessness. All of the mental health centers report on services to the homeless population. Each mental health center has the capability of serving the homeless through a wide array of residential services. They do not necessarily have the capacity to serve everyone in need. Housing is usually an issue listed by the providers.

Description of PATH, Shelter Plus Care, and HUD grants

This office contracts with ten mental health centers to provide Homeless Outreach Teams through the PATH Grant Program. The teams are located in the most densely populated areas of Indiana: Central Indianapolis, Fort Wayne, Lake County (two centers), South Bend, Elkhart, Bloomington, Evansville, Anderson and Muncie. The PATH funding was reduced this year but we will continue to fund the ten teams that are presently operating.

The teams provide the following services:

- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Staff training
- Case management services
- Supportive and supervisory services in
- Residential services
- Referrals for primary health services
- Job training and educational services
- Housing services

All the PATH teams are a part of comprehensive community mental health centers and the full continuum of services are available to persons who are homeless that are enrolled in treatment services. All of the PATH sites have a certified ACT team operating in the agency. A history of homelessness is one of the ACT admission criteria.

The target population for the Mobile Homeless Outreach Teams is the homeless individual who is mentally ill and has problems that require professional intervention. Homeless has been defined as including individuals who:

1. May live on the street, in cars, or in abandoned structures or public places;
2. Are housed in emergency shelters and other places not considered home;
3. Are living with friends or relatives in crowded, unhappy, and stressful circumstances;
4. Are living in deteriorated, unsafe housing, often lacking utilities; or
5. Are involved in support programs without which they would be at high risk of homelessness. Some of these individuals may be "chronic" street people while some are on the streets on an episodic basis.

As part of the PATH grant application this office developed a definition of the “at-risk of homeless population”.

“A person at imminent risk of becoming homeless includes those who are:
- living with friends or relatives in a sequence of living arrangements
- living in a condemned building
- facing an eviction notice
- in a county jail with no housing available upon release
- in a psychiatric inpatient unit with no housing available upon release”

The PATH teams have established excellent relationships with the local shelters. In some cases this relationship has made it too easy for the PATH workers to find the homeless and they were not “working the streets” as they used to do. This office made several visits to the PATH sites and encouraged a return to outreach to the homeless street

people. Reports from those teams show that they are doing just that and they are enjoying the new focus.

This office created a policy that prohibits a discharge from state operated mental health hospitals to homelessness. That policy was reviewed and approved by the DMHA Policy Development Committee and distributed to all applicable agencies.

Shelter Plus Care has been successfully funded at seven mental health centers, one Mental Health Association and a project headed by a local Catholic Charities. For many years this office oversaw the Shelter Plus Care projects. It was decided during the past year that the Shelter Plus Care projects would be better placed at the Indiana Housing and Community Development Authority. The seven projects that were under the DMHA plus two more Shelter Plus Care projects under a sister agency within FSSA were transferred to IHCDA. The staffing of IHCDA, with 15 grant monitors, has the potential to offer much more grant oversight than this office could provide. This office will remain in close contact with IHCDA to work with the CMHC based Shelter Plus Care projects and future applications.

The Indiana Housing and Community Development Authority sponsors the Interagency Council on the Homeless (IAC) comprised of the highest level decision-makers from state agencies involved in homeless issues. The IAC has membership of the Housing and Community Development Authority, Department of Correction, Department of Veterans Affairs, Department of Health, and two offices of Family and Social Services Administration: the Division of Family Resources; and the Division of Mental Health and Addiction.

A subcommittee of the IAC attended *Improving Access to Mainstream Services for People Experiencing Chronic Homelessness*, a Policy Academy for State and Local Policymakers, in Chicago. As the result of that event, the subcommittee has published an Indiana *Action Plan to End Chronic Homelessness*.

Definition of rural locations in the state and description of the urban/suburban/rural mix

The Division has established a definition of rural: those counties with fewer than 100 persons per square mile.

As a result of the census of 2000, we remain a rural state but we have changed from 62 to 63 rural counties. The number of people living in rural counties has slightly increased by 0.64% (1,545,000 to 1,555,000) while the whole state increased by 9.7% (5,544,000 to 6,080,000). The percentage of people living in rural areas has changed from 27.8% to 25.6%.

This office did a survey of rural providers and several rural providers were interviewed to discuss the success of rural providers in the area of outreach and engagement of consumers in rural areas. Some providers are very active in the school systems, providing therapists who work with children. Most have increased the number of case

managers. Most believe that they have very good relationships with local Department of Child Services and Division of Family Resources offices and law enforcement. It became clear that the rural mental health centers are one of the major employers in the community and the rural providers have a higher level of standing and recognition in the community than do many of the urban providers. One provider commented that they have established auxiliary offices so that there is an office within 30 minutes of everybody in the service area. All interviewed said they had a high level of coordination with other service providers in the area.

This office is very proud of the rural coverage that exists. For the past several years we have monitored the levels of service in rural areas and found that penetration rates are virtually the same in rural areas as in urban areas.

Strengths:

- PATH funds have made it possible to continue funding for the ten teams.
- Rural penetration rates continue to be comparable to urban services indicating accessibility of services in all areas of the state.

Weaknesses:

- Many rural centers feel they do not have adequate numbers of people meeting the admission criteria of ACT to justify establishing that EBP.
- There are some early discussions that the service array in urban counties may richer than in rural counties.

Criterion 5
Management Systems

Financial and staffing resources…which will be needed to implement the plan.

It has long been the practice of DMHA to place the Block Grant funds in the general treatment funding pool along with state general revenue funds and SSBG funds. Funds are distributed to providers based on a funding allocation formula based on levels of services from the previous year. This system does not allocate Block Grant funds proportionally. At the end of the contract year we are able to track funding sources for each contactor so that we are able to show where Block Grant funds were expended. The planning committee would like to earmark some of the Block Grant funds for consumer operated programs. We are considering a change in funding allocation to use Block Grant funds for the consumer operated statewide agency. This has not been finalized.

During the past year all agencies within FSSA were asked to revert 7% of the state funds for programs. This reduction placed us out of compliance with the MOE requirements. There were a series of meetings with the FSSA fiscal office to discuss the potential impact of this reduction and the potential loss of Block Grant funds. This spring funds were released in an amount that made it possible to meet MOE. However, that still meant

that the overall state general funds for community mental health services were reduced by X%.
At this time we are looking at a similar directive for reductions for SFY '07. The same discussions will take place regarding the MOE.

The following table represents the various funds available for the purchase of services for the SMI population. Not shown on this table are the federal Medicaid Rehabilitation Option funds that the providers access during the year.

Comparison of DMHA Funds for Mental Health Centers for SMI Services
State Fiscal Year 04 to 06

	Adult Services	Social Services Block Grant	Mental Illness Block Grant	TOTAL
SFY 04	$75,984,704	$3,565,296	$3,000,000	$82,500,000
SFY 05	$77,219,397	$4,617,409	$4,148,144	$85,984,950
SFY 06	$77,205,000	$4,254,000	$4,148,000	$85,964,600

Description of the role of the MHBG program in the state, including innovative services funded by the grant.

Emergency Health providers

All Indiana providers have a relationship with local emergency providers. In some instances there is staff from the mental health center at the ER to assist in evaluations. One provider noticed problems with law enforcement and the transportation of individuals to court. They trained a small group of law enforcement officers who now volunteer for transportation duty. This has reduced the trauma of such transportation. Another provider, more than 15 years ago, started training local law enforcement and emergency responders following an airplane crash in their area. Several agencies have adopted the Memphis model. There are also providers that have established mobile crisis units that respond with law enforcement when called on a disturbance involving a potentially mentally ill individual.

Emergency response personnel receive training from the State Emergency Management Agency (SEMA). SEMA contracts with a community mental health center to provide to emergency response personnel Crisis Counseling Intervention techniques. Since 9/11 the Governor created the Homeland Security Agency (HSA) for Indiana, to respond to terrorist activities that may affect citizens, business, and government activities. The Indiana involvement in sending a response team to Louisiana after the hurricane has lead to the development of a standing trained emergency response team.

The Indiana Division of Mental Health has revised the Indiana State Mental Health Disaster Plan. The reason for this revision was to integrate our plan with the Indiana Department of Homeland Security Response Plan. When the Governor's Counter Terrorism Task Force and the Indiana Department of Homeland Security were merged to form the Indiana Department of Homeland Security they required that all agencies review their state plan and to reformat it; so it would be integrated into the new state plan. The Indiana Mental Health Disaster Mental Health plan was revised and has been accepted by the Director of the Indiana Department of Homeland Security.

The Indiana Division of Mental Health and Addiction was given the task of development for the Indiana State Department of Health a behavioral plan to work with first responders especially for those who will respond following the onset of the avian flu.

The Indiana Division of Mental Health and Addiction conducted its second level clinical training in April. The training brought together 75 clinicians from across the state to begin the process of registering our crisis counselors. The three day training used a curriculum that was developed by members of our All Hazards Committee. The State of Indiana has begun to see the importance of developing our own instate experts to provide this training. The State of Indiana will repeat this training in each of the ten Homeland Security districts. This training is in conjunction with the development of the local planning efforts that have begun in each of the ten districts.

At our recent Indiana Pandemic Summit that was sponsored by our Governor Mitch Daniels and Health and Human Service Secretary Michael Leavitt, there were 9 breakout sessions for participants to attend and one of the breakouts was on mental health issues that would surround a pan epidemic, and how would the state respond.

The Indiana Division of Mental Health and Addiction is currently working with Developmental Disabilities agencies interested in disaster mental health services.

The Indiana Department of Homeland Security continues to be very important partner. The Indiana Division of Mental Health and Addiction is a part of the Hoosier Task Force; this task group is being developed to respond to any disaster, whether within the State of Indiana or out of state through the EMAC (Emergency Management Assistance Compact). When the Indiana Department of Homeland Security was putting together their application for funds through the Federal Department of Homeland Security, a request for monies for the Indiana Division of Mental Health and Addiction was made for training.

The Indiana Department of Homeland Security has asked the Indiana Division of Mental Health and Addiction to be a member of their newly created DMORT Team (Disaster Mortuary Team). The role of mental health on this team would be to work with the DMORT team members during a deployment and to assist in the development and coordination of the DMORT family assistance center.

The Indiana Division of Mental Health and Addiction is working with the Indiana Department of Homeland Security and the Indiana State Department of Health in the development of training online through the Learning Management System out of the University of Illinois- Chicago.

It should be noted that a member of the Indiana Legislature was a member of the Indiana team that assisted after Katrina. She was instrumental in securing House Concurrent Resolution #2, recognizing the efforts of the Indiana response team.

Plans to reallocate resources or expand funding to Community Based Services

This office has reallocated resources from state operated facilities to community based services in several ways. The closure of Central State Hospital increased our community based funding by $5 million. Since that closure we have continued to reduce the numbers of beds in the SOF's and have moved those funds to the community. We have instituted a SOF agreement type that creates a premium payment rate for CMHC's taking long-term individuals out of SOF's and providing community treatment. During 2006, 236 such individuals were served in the community instead of an institution. As this office moves ahead with transformation, there will be a continued effort to emphasize community based services.

Planning Council Recommendations

Develop a policy for reduction of treatment waiting lists

> There are several CMHC's that measure waiting times for treatment and use that measure as a quality indicator. This office will discuss with those providers their process and the affect their measures have had on reducing the waiting lists. That information will be shared with other providers and considered as a policy by this office.

Examine access to in-patient beds at SOF's and at CMHC's.

> The SOF's continue to be used by those with direct access reducing the bed availability to the community providers. CMHC's are utilizing their inpatient beds more often. There is often a wait for beds.
>
> This will require some further examination during this year to determine the wait times and the number of people that are forced to wait and in what setting they wait.

Explore changes in Medicaid rules so that inmates in state prisons would not lose Medicaid coverage but it would be suspended to allow for a quicker return to Medicaid coverage upon release.

> Present practices take an inmate off of Medicaid benefits upon incarceration. This means that upon release the former inmate must re-apply for Medicaid coverage and that application can take a long time. There are no provisions that allow for application to be made while in prison. If an inmate is receiving mental health treatment in prison and needs to continue that treatment upon release there is the potential of a lapse in services until Medicaid is reinstated.
>
> This has been discussed with our in-office Medicaid person. The recommendation would require a change in Medicaid rules; presently an unpopular course. This will remain an ongoing issue.

All CMHC funding should be results based.

> The present funding system is based on enrollment of eligible individuals. The recommended change would require a change in our funding system, not an easy proposition. We are using the CSR's that look at services and outcomes and projected outcomes of treatment and that may be related to funding at some point. We are using our data to identify the levels of services provided by treatment agencies. This is a long term recommendation that will need further consideration.

Consumers should be able to change SOF gatekeeper.

The present system is designed to have a CMHC gatekeeper work with the consumer and the SOF treatment team so that the gatekeeper is involved in treatment planning and discharge planning. If a consumer decides that they want to go to another community upon release from the SOF a new gatekeeper would have to become involved in the design of the discharge plan and community placement. The gatekeeper rule does not speak to such a transfer. There are other matters that may complicate what seems a simple change: enrollment payments and bed allocation are two. This matter may be best resolved with the development of a policy rather than a rule change.

Expand services to include peer to peer.

Peer to peer services are being used at some ACT teams and some IMR sites. Some CMHC's have hired consumers as case managers. These examples could be used to encourage other providers to use peer to peer supports.

The Planning Council should accommodate the child care, transportation and out of pocket expenses for members.

We are presently limited by state regulations on the payments for council members. Those regulations are limited to payment of mileage and in some cases overnight lodging. We cannot pay for the other expenses. There have been discussions of other ways to handle such reimbursements. This office will continue to consider such payments.

SECTION III (ADULTS)

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

Criterion 1 (National Outcome Measures)

Goal A: Adults with SMI will receive appropriate and comprehensive community-based services.

Target: To maintain current levels of readmission to state psychiatric hospitals at 30 days and 180 days post discharge.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Reduced Utilization of Psychiatric Inpatient Beds***

Indicator: The number of persons who are discharged from a state psychiatric hospital during the fiscal year who are re-admitted to a state psychiatric hospital at 180 days.

Measure: Numerator: Number of persons, aged 18+, who are readmitted to a State hospital within 180 days.
Denominator: None.

Source: The state hospitals maintain a database that is separate from the community services database. Information about admission and discharge is contained in that database for each individual served.

Special Issue: The state psychiatric hospitals are medium- to long-term care facilities. Therefore, the number of readmissions at 30 days is less than 5 persons and is an indicator used by the state psychiatric hospital system to monitor quality. The 180 days readmission also tends to be quite low but is being included here in order to comply with reporting National Outcome Measures.

Significance: This measure monitors the effectiveness of community services for persons who have been discharged from state psychiatric hospitals. As Indiana proceeds to localize (privatize) state psychiatric hospitals, monitoring both 30 day and 180 day readmissions will become an essential quality indicator for both community and hospital services.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Reduced Utilization of Psyc. Inpt. Beds***	6.5%	5.2%	7.2	7.0%	
Numerator	29	30	37		---
Denominator	447	572	508		---

Goal B: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Targets: To increase the number of evidence-based practices provided by the community mental health system.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Evidence-Based Practices Provided***

Indicator: The number of evidence-based practices being provided in the state.

Measure: Numerator: For each of the seven adult evidence-based practices (ACT, IDDT, IMR, Family Psycho-Education, Supported Housing, Supported Employment and Medication Algorithms), indicate (Yes-No) whether it is being provided.
Denominator: None

Source: DMHA supports the development of five of the evidence-based practices.

Special Issue: Implementation of evidence-based practices requires a significant investment of resources (both money and personnel). With the state experiencing budget deficits and needing to cut funding, there is a risk that continuing development of these practices may be slowed. The State is not supporting the development of Supported Housing or Medication Algorithms at this time.

Significance: This measure monitors the implementation of evidence-based practices by providers. Acceptance of and implementation of these practices following fidelity models is intended to improve the outcomes for adults with serious mental illness.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator ***EBP Provided (Y or N***)					
ACT	Y	Y	Y	Y	
IDDT	Y	Y	Y	Y	
IMR	Y	Y	Y	Y	
Family Psycho-Education	Y	Y	Y	Y	
Supported Employment	Y	Y	Y	Y	
Supported Housing	N	N	N	N	
Medication Algorithms	N	N	N	N	

Goal C: Consumers will have access to appropriate Evidence Based Practices.
Targets: To increase the number of consumers receiving evidence-based practices by 5% each year.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Use of Evidence-Based Practices by Consumers***
Indicator: The number of adult consumers with SMI receiving evidence-based practices during the year.
Measure: Numerator: Number of adults with SMI, aged 18+, who are receiving any of the four evidence-based practices implemented within the State.
Denominator: None
Source: As of state fiscal year 2006, community mental health centers are required to enter information into the state database for each individual receiving ACT, Supported Employment, IDDT, and/or IMR.
Special Issue: The state database currently captures information about four evidence-based practices at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's participation in one or more of the practices may begin after enrollment or after the reassessment. Therefore, the counts are not considered truly representative of the numbers of persons actually involved in the evidence-based practices at any time during the fiscal year. Reassessments are not consistently reported by the providers. Family Psycho-education is provided by NAMI-Indiana through a contract with the state. However, these activities are not tied to specific consumers and, therefore, counts of consumers' families receiving this practice is not available.
Significance: This measure monitors the implementation of evidence-based practices by providers. Acceptance of and implementation of these practices following fidelity models is intended to improve the outcomes for adults with serious mental illness.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Use of EBP by Consumers***	n/a	n/a	4,800	7,200	
Numerator	n/a	n/a	4,800	7,200	
Denominator	n/a	n/a			

This goal and the data for it began in 2006, no earlier data are available.

Goal D: Consumers will report positively about outcomes.
Target: To increase the number of consumers reporting positively about outcomes.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Outcome***
Indicator: The number of consumers reporting positively about treatment outcomes.
Measure: Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total responses reported in the outcome domain on the adult consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Consumer perception of the outcomes derived from their treatment services is the most sensitive domain on the adult consumer survey. Therefore, improvement in this domain will indicate general system improvement in the quality of services being provided.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Outcome***	71.6%	69%	66%	66%	
Numerator	1,193	1,205	---		---
Denominator	1,667	1,821	---		---

Criterion 1 (State Level Measures)

Goal E: Consumers will report positively about accessibility of services.
Target: To increase consumer's positive response regarding accessibility.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Accessibility***
Indicator: Numerator: Number of positive responses by adults with SMI to the question "services are available at times that are good for me".
Denominator**:** Total number of responses by adults with SMI to the question, "services are available at times that are good for me".
Measure: Percentage of persons with serious mental illness that report positive responses "services are available at times that are good for me" on the MHSIP Consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Accessibility of services at times that are convenient to the consumer can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Accessibility***	81.2%	77.3%	77%	77%	
Numerator	1,443	1,516		---	---
Denominator	1,778	1,961		---	---

Goal F: To provide case management services for all adults receiving services through the public mental health system who are in need of these services.
Target: To increase by two percent the percent of individuals with a serious mental illness who receive case management.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Case management***.
Indicator: Percentage of adults with serious mental illness who receive case management services among those who receive public mental health services.
Measure: Numerator: The number of adult recipients with a serious mental illness who are receiving case management services during the fiscal year.

Denominator: The number of adults who receive public mental health services during the fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.

Special Issue: None.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Performance Indictor Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Case Management***	58%	61%	61%	60%	
Numerator	27,747	32,395	33,100	---	---
Denominator	48,037	53,110	54,008	---	---

Goal G: Consumers will report positively about the quality and appropriateness of services.

Target: To increase consumer's positive response regarding quality and appropriateness of services.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Quality of Care***

Indicator: Numerator: Number of positive responses by adults with SMI to the questions in the Quality/Appropriateness domains.
Denominator**:** Total number of responses by adults with SMI to the questions in the Quality/Appropriateness domains.

Measure: The percentages of persons with a serious mental illness have positive responses to the Quality/Appropriateness domains on the MHSIP Consumer survey.

Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: Meeting the treatment needs of consumers can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Table

	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Quality of Care***	83.7%	82%	83%	80%	
Numerator	1,470	1,593	---		
Denominator	1,756	1,930	---		

Goal H: Consumers will report positively about their general satisfaction with services.
Target: To increase consumer's positive response regarding general satisfaction with services.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Satisfaction***
Indicator: Numerator: Number of positive responses by adults with SMI to the questions related to general satisfaction.
Denominator**:** Total number of responses by adults with SMI to the question related to general satisfaction.
Measure: The percentage of persons with serious mental illness that report positively on the general satisfaction with services items on the MHSIP Consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Accessibility of services at times that are convenient to the consumer can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Estimated	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Satisfaction***	81.5%	79%	80%	80%	
Numerator	1,457	---	---	---	---
Denominator	1,788	---	---	---	---

Goal I: To improve the employment status for adults with SMI receiving services through the public mental health system.

Target: To increase by two percent the percentage of adults with a serious mental illness who are employed from one year to the next.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Percentage Employed***.

Indicator: Percentage of adults with serious mental illness receiving services through the community mental health system who report being employed.

Measure: Numerator: The number of adult consumers with a serious mental illness who are employed during the current fiscal year.
Denominator: The number of adult consumers with a serious mental illness who are enrolled during the current fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Information about employment status of each consumer is entered into the database by the providers of service at annual enrollment and reassessment.

Special Issue: The state database currently captures information about employment status at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's employment status may change after enrollment or after the reassessment.

Significance: Consumers report that being employed is one of their major goals. However, employment statistics reveal significantly lower rates of employment for these consumers than the rates of employment for the general population. Therefore, improving the employment rates for consumers should help promote their recovery.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Percentage Employed***	21%	20%	21%	20%	
Numerator	10,536	10,634	11,441		
Denominator	50,542	52,910	53,552		

Goal J: To improve the independent living arrangement for older adults with SMI receiving services through the public mental health system.

Target: To increase by two percent the percentage of older adults (aged 65+) with a serious mental illness who are living independently from one year to the next.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Percentage Older Adults Living Independently***.

Indicator: Percentage of adults aged 65+ with serious mental illness receiving services through the community mental health system who report living in a home or apartment.

Measure: Numerator: The number of adult consumers aged 65+ with a serious mental illness who are living in a home or apartment during the current fiscal year.
Denominator: The number of adult consumers aged 65+ with a serious mental illness who are enrolled during the current fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment and reassessment information related to living arrangement is entered into the database by the providers of service.

Special Issue: The state database currently captures information about living arrangement at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's living arrangement may change after enrollment or after the reassessment.

Significance: Older adults desire to retain their independence as long as possible. Therefore, living independently, rather than in some type of congregate setting, is a way to preserve this independence.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Percentage of Older Adults Living Independently***	46%	47%	48%	50%	
Numerator	1,579	1,629	1,610	---	---
Denominator	3,466	3,461	3,386	---	---

Criterion 2 (National Outcome Measures)

Goal A: Persons in need of publicly supported mental health services will have access to services.

Target: To maintain the current level of access to services.

Population: Adults with a serious mental illness.

Criterion: Mental Health System Data Epidemiology.

Brief Name: ***Access***

Indicator: The number of unduplicated adults with SMI that are enrolled in mental health services during the fiscal year.

Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***Access***	FY 2004 Actual	FY 2005 Actual	FY2006 Estimated	FY 2007 Target	FY 2007 Attain
Number Enrolled	50,542	52,707	53,552	53,552	
18 - 20	2,756	2,786	2,786	2,786	
21 - 64	44,467	46,460	47,380	47,380	
65 – 74	1,821	1,886	1,961	1,961	
75 +	1,498	1,575	1,425	1,425	
Gender	50,542	52,707	53,552	53,552	
Male	19,570	20,530	20,731	20,731	
Female	30,972	32,177	32,821	32,821	
Race/Ethnicity	50,542	52,707	53,552	53,552	
American Indiana or Alaska Native	195	221	422	422	
Asian	117	120	136	136	
Black or African-American	5,799	6,078	6,226	6,226	
Native Hawaiian or other Pacific Islander	17	23	61	61	
White	43,153	45,020	44,775	44,775	
More than one Race	206	267	926	926	
Race Not Available	1,055	978	1,006	1,006	
Hispanic	1,482	1,492	1,577	1,577	

Criterion 2 (State Level Measures)

Goal B: Persons in need of publicly supported mental health services will receive services.

Target: To maintain the current penetration rate of persons estimated to be in need of Hoosier Assurance Plan services.
Population: Adults with a serious mental illness.
Criterion: Mental Health System Data Epidemiology.
Brief Name: ***Penetration Rates***.
Indicator: The percentage of persons eligible for Hoosier Assurance Plan services who receive the services.
Measure: Numerator: The number of persons with SMI and Co-Occurring Disorder who receive publicly funded services under the Hoosier Assurance Plan. Denominator: The number of persons with incomes at or below 200% of the federal poverty level who are estimated to be in need of services.
Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service. Prevalence Reports produced by DMHA.
Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.
Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Estimated	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Penetration Rates***	76%	78%	81%	80%	
Numerator	50,542	53,110	53,552	52,900	---
Denominator	66,129	66,129	66,129	66,129	---

Criterion 4 (State Level Measures)

Goal A: Persons who are homeless and in need of publicly supported mental health services will have access to services.
Target: To maintain the current level of access to services.
Population: Adults with a serious mental illness.
Criterion: Targeted Services to Homeless Populations.
Brief Name: ***Homeless Access***
Indicator: The number of unduplicated adults with SMI who are homeless that are enrolled in mental health services during the fiscal year.

Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder who are reported as homeless.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY 2005 Actual	FY2006 Estimated	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Homeless Access***	2,780	3,513	2,755	2,700	
Numerator	2,780	3,513	2,755	2,700	---
Denominator	---	---	---	---	---

Goal B: Persons who live in rural areas of the state and in need of publicly supported mental health services will have access to services.

Target: To maintain the current level of access to services.

Population: Adults with a serious mental illness.

Criterion: Targeted Services to Rural Populations.

Brief Name: ***Rural Access***

Indicator: The number of unduplicated adults with SMI who are living in rural areas of the state and are enrolled in mental health services during the fiscal year.

Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder who are living in rural areas of the state.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Over 68 % of Indiana's counties are rural with slightly over 72% of the population aged 18 and over living in urban counties. Of the adults with

serious mental illness served by the public mental health system, approximately 69% live in urban counties and 31% live in rural counties.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indictor Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimated	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Rural Access***	15,021	16,345	16,376	16,300	
Numerator	15,021	16,345	16,376	16,400	---
Denominator	---	---	---	---	---

Criterion 5 (State Level Measures)

Goal A: Public funding for the community mental health system will remain stable or increase.

Target: To stay within 10% of the state fiscal year 2006 expenditure of DMHA funds for the purchase of services for adults with serious mental illness.

Population: Adults with a serious mental illness.

Criterion: Management Systems.

Brief Name: ***DMHA Funds***

Indicator: The amount of DMHA funds expended for adults with serious mental illness.

Measure: Numerator: The amount of funds allocated for services for individuals with agreement types of SMI and Co-Occurring Disorder.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY 2006 Estimate	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***DMHA Funds*** (in 000's)	96,000	104,750	110,300	110,000	
Numerator	96,000	104,750	110,300	110,000	---
Denominator					---

SECTION II. (CHILD AND ADOLESCENT)

IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEMS STRENGTHS, NEEDS, AND PRIORITIES

Criterion I: Comprehensive Community-based mental health services systems

Publicly funded children's mental health services in Indiana are financed through five separate state agencies, each with distinct eligibility requirements. The **Office of Medicaid Policy and Planning** supports primary medical and mental health services and dental services for children. Medicaid is the largest purchaser of services through Hoosier Healthwise (a managed care program) and the SCHIPS program. Medicaid successfully secured a 1915(c) Home and Community-based Waiver for children with serious emotional disturbance (SED Waiver) assuring the option of community care for a limited number of children/youth that are eligible for State Psychiatric Hospital admission. The state Medicaid plan also includes Psychiatric Residential Treatment Facilities for children whose psychiatric treatment is medically necessary and requires a secure, 24 hour treatment facility. The Medicaid Rehabilitation Option provides for community-based case management services.

The **Department of Child Services** (DCS) funds services for CHINS (children in need of services) through each county. Children's services supported by the **Department of Child Services** and the **Division of Family Resources** include: child protection and placement, First Steps Early Intervention (part C), Title IV-E waiver program, TANF, Independent Living, Healthy Families, alternative living, preventative health care, child care services, parenting skills, and licensing of child placing agencies. During 2006 there has been significant collaboration between DMHA and DCS, as we implement the Early Identification and Intervention Initiative, providing mental health screening for all children/youth entering the child welfare system. DCS and DMHA collaborate on program planning and policy development for Drug Endangered children.

The **Department of Education** provides for a range of services: school-wide prevention programs (to enhance social/emotional functioning), general education intervention (first response to learning difficulty), Article 7: Special Education Services and Section 504 for students with disabilities. National statistics project that 4% of the school population will be classified as emotionally disturbed; Indiana report 1.4% as emotionally disturbed. The Division of Exceptional Learners of the Department of Education (DEL/DOE) provides funding for intensive services to youth who cannot be educated using existing local resources. Special Education representatives frequently serve on SOC governing consortiums. Schools also refer children to the SED Waiver.

Youth remanded to the **Department of Correction** (DOC) must complete individual improvement plans. There is a concerted effort on the part of DOC to reduce the amount of time a youth may spend in their care by developing re-entry programs, with a focus on working with the offender's family. Within the DOC, the Community Correction

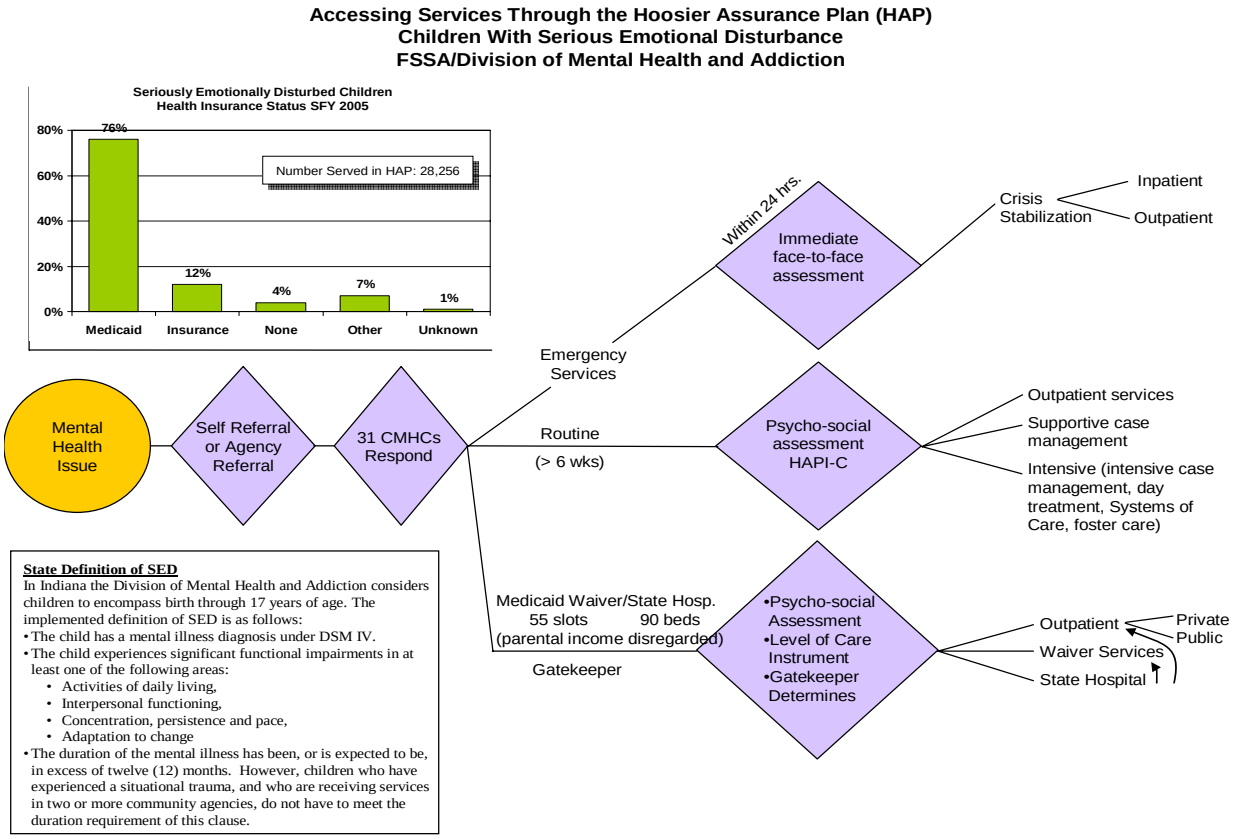
Division supports community-based interventions to divert youth from incarceration, and in some communities Systems of Care are used to support this goal.

The **Division of Mental Health and Addiction** (DMHA) funds community-based child services through a network of providers. About 10% of the DMHA budget is allocated for community based programs targeting children with serious emotional disturbance (SED) whose families/caregivers are at or below 200% of poverty. DMHA also supports 90 children's beds at three state hospitals. Children are served by the DMHA through one of 31 Community Mental Health Centers or other contracted care providers, with multiple locations thought the state. Children are assessed with the Hoosier Assurance Plan Instrument for Children (HAPI-C), with income eligibility established on a family income at or below 200% of the Federal Poverty Level (FPL). The goal of the Hoosier Assurance Plan is to assure community-based services. The HAPI-C measures the child's level of functioning and self-management skills relative to the child's appropriate development. The Hoosier Assurance Plan is designed to equalize the availability and quality of community-based mental health and addiction services across the state for those most in need with an array of mental health services. Level and intensity of services are determined though developments of an individualized treatment plan.

Each CMHC reaches a primary service area to assure adequate statewide coverage. The Community Mental Health Centers are gatekeepers for the state hospital system, fostering collaboration between the CMHC and the hospital. With the implementation of the SED Waiver in 2003, a Level of Care application is required for every potential child/youth admission to the state hospitals. The application process requires an assessment of the adequacy of attempts to provide community care prior to hospitalization. Gate keeping responsibilities include monitoring of the hospital stay, case management duties, discharge planning and follow-along services. Face to face quarterly meetings with the child/youth and family are required.

Community Mental Health Centers and other providers are required to provide a range of services for children. Indiana Administrative Code defines the populations to be served, the continuum of care, and minimum standards for the provision of services. Minimum standards for the following components of a continuum of care are defined in state law as: case management, outpatient services, medication evaluation and monitoring, and family support.

The following chart shows how children's services are delivered.



The **continuum of care** assures adequate services for youth with substance abuse and/or co-occurring mental health issues. Services range from substance abuse education to intensive out patient programs. We continue to work toward integrated treatment for both substance abuse and mental health needs. Working collaboratively with the **Substance Abuse Prevention and Treatment** (SAPT) block grant, training was secured for providers in an EBP for youth with marijuana usage. The Cannabis Youth Treatment (CYT) program is a time-limited, manualized approach engaging youth in a cognitive process to look at their use and choices. Once providers are trained, the Technical Assistance Center for Systems of Care may offer ongoing coaching and training to support the implementation of the program.

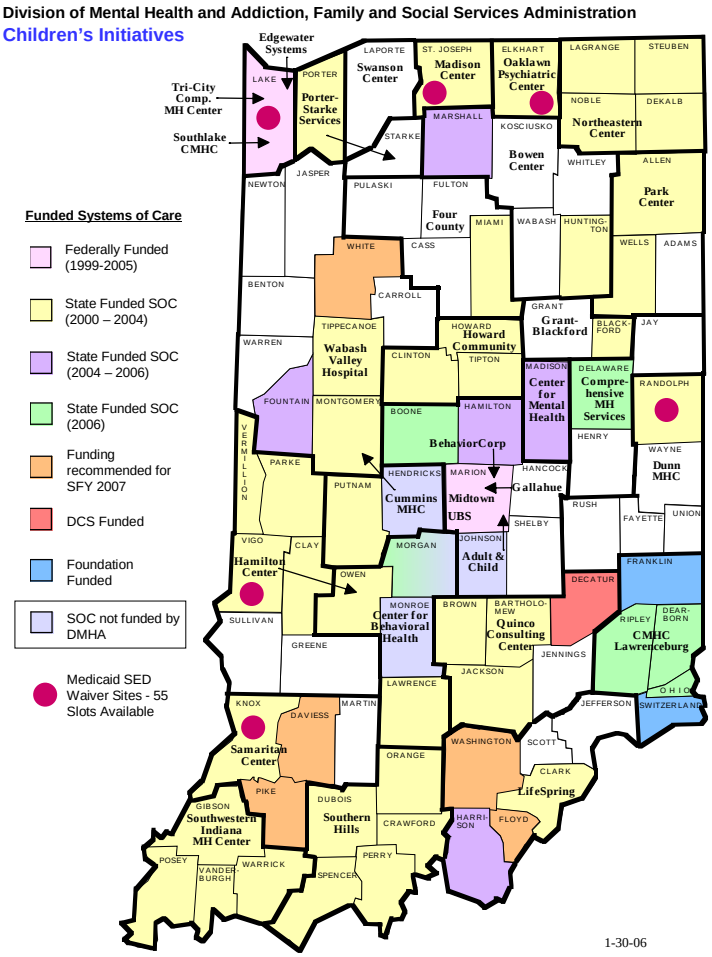
With the recently awarded **Strategic Prevention Framework** grant by SAMHSA, a community-based approach to substance use prevention and mental health promotion is being developed. The Task Force has identified underage drinking and methamphetamine use as the primary targets. The Plan will be released in late summer of 2006.

Indiana continues to move forward by supporting the **implementation of effective models of care** in children's social, emotional and behavioral health, as a means to transform the state's mental health system. . The Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and their Families partners with

DMHA in the creation, implementation and sustainability of an accountable system of care that uses real-time process and outcome data to continuously improve the quality of services and that makes effective models of care available to all children/youth with mental health needs and/or substance use problems and their families..

Three **state hospital** units serve children. A localization process will eventually remove one of these units from the state operation. . State hospital capacity for children is 90 beds. One of the units serves adolescent males, another serves children 5 through 12 and the third serves all youth. The facility serving younger children seldom reaches capacity. Each year, for the past three years, the number of children served has declined.

Since the mid-1990's **children's Systems of Care (SOCs**) have developed throughout the state to serve children with serious emotional disturbances and their families. Some were initially supported by state funds and others solely through community efforts. Beginning in 2000, DMHA offered seed funding for newly developing SOCs. At the beginning of SFY 2007 there are 40 SOCs, including 2 federally funded sites which have completed their seven years of funding. Two-thirds of Indiana counties are served by SOCs, in various stages of development. During SFY 2006, 972 children were enrolled in SOCs, which equates to approximately 2.1% of all children served in the community public mental health system during 2006.



Since 2003 the **Technical Assistance Center for Systems of Care and Evidence-based Practices for Children and Families (TAC)** has served as the champion for SOC development. Funded by the state, the TAC offers training, coaching and mentoring to all of the SOC sites. As one of only two such Centers in the country, the TAC has consulted with and trained SOC trainers with the National Technical Assistance Center for Systems of Care, Georgetown University. The TAC annually conducts a site assessment of each of the state's SOC sites, measuring its developmental level, as well as administering a Wraparound Fidelity Index. Individual SOCs utilize this information to improve their functioning. The SOC coaches have, at minimum, monthly site visits with each site, as well as frequent electronic and telephone consultation. Recently, one of the coaches was selected to participate in the Training of Trainers Working in Spanish Speaking Communities. In December 2005 the TAC was identified as an "innovative and exceptional practice in child and adolescent workforce education by the *Annapolis Coalition on the Behavioral Health Workforce.*

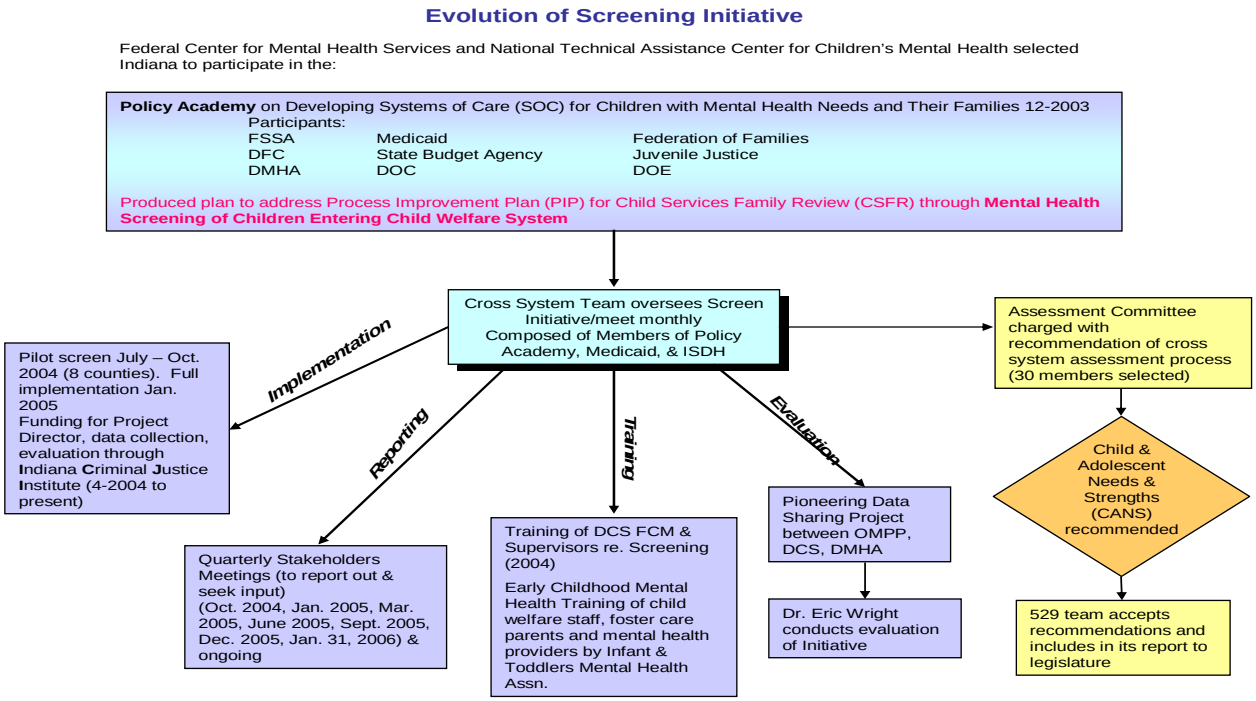
Matching funds for the **1915(c) waiver** are braided from Department of Correction (DOC), Department of Education (DOE), State Medicaid and DMHA. Consumer choice

for SED children and their families has been expanded with the approval of the SED waiver. The menu of possible services includes case management/wraparound facilitation, family support and training, independent living skills and respite care. Since its inception the waiver has served 43 children and their families. Of these, 35 were diverted from state hospitalization, and 8 were taken out of the state hospital. Two children went into the state hospitals from the waiver, and two others entered PRTF (psychiatric residential treatment facilities) directly from state hospitals while awaiting waiver approval.

DMHA is a "core partner" with the **Indiana State Department of Health** (ISDH) in planning for a more comprehensive early childhood system. In this process state agencies, community partners and families collaborate to develop a strategic plan leading to a coordinated, comprehensive, community-based system of service for young children. This process is supported by a planning grant from the Federal Maternal and Child Health Bureau. DMHA shares joint ventures in suicide prevention and disaster management planning. Mental health services are included in the ISDH annual budget. Through this joint venture Indiana was the first mental health team to be deployed through an Emergency Management Agency Compact (EMAC) Order following Hurricane Katrina. DMHA furnishes prenatal substance abuse education through ISDH programs.

In response to Indiana's mandated Process Improvement Plan for the Department of Child Services, the **Early Identification and Intervention Initiative** has administered mental health screening and assessment services (if indicated) to over 6,000 children who have entered the child welfare system. The Initiative began as Indiana's 2003 Policy Academy delegation, which subsequently became the Cross-System Team overseeing the work of the Initiative. Quarterly stakeholders meetings are held to report the progress of the initiative. Utilizing multiple data sources (Medicaid, DMHA, DCS) the initiative is evaluated by the Center for Urban Policy and the Environment, Indiana University-Purdue University Indianapolis. Preliminary conclusions indicate that the screening initiative is getting more children into behavioral treatment sooner. An Early Intervention Project Director serves as liaison among the systems, and coordinates early childhood mental health trainings for providers, foster parents and DCS staff. This position is funded through a grant by the Indiana Criminal Justice Institute.

The Cross-Systems Team selected a group of providers, clinicians, family members to study and recommend the adoption of an assessment process that can be used in all child serving systems. The recommended tool, the **CANS** (Child, Adolescent Needs and Strengths), met the selection criteria of: usefulness to child and family, informing the care plan, decision support, providing outcomes and potential use for risk adjusted funding. Medicaid supports the use of the CANS as a means to achieve accountability, and plans to adopt its use. The Department of Corrections will begin using it in October 2006. DMHA providers will start using it in SFY 2008. DCS and DOE also plan to use the CANS at some future point. An interagency work group is developing detailed implementation plans which include training/certification, specific system and cross system use of the tool, algorithms to inform level of care decisions, a data collection system and quality management processes.



During 2006, the Division's **Office of Consumer and Family Affairs** (OCFA) offered Wellness Recovery Action Planning (WRAP) for families of children with SED, advocated for funding to support peer provided services to families and educated the DMHA Advisory Council about the research showing peer support is an evidence-based practice. Indiana now has three Advanced WRAP Facilitators who are qualified to certify other WRAP facilitators. Over 700 persons have been trained during SFY 2006. The OCFA has been a driving force in advocating for transformation to a Recovery Based System of Care. The OFCA Bureau Chief is the lead staff for the Transformation Work Group subcommittee on Consumer and Family Involvement. The Office has taken leadership in the reduction of coercion, and leadership development and self-advocacy training, reaching close to 1,000 persons. The number one goal for the OFCA in SFY 2007 is to promote the development of effective individualized services for children who have complex needs and their families. The OFCA manages an active list serve, reaching over 150 persons with research, evaluation and educational material.

DMHA has contracted with **Families Reaching for Rainbows** for technical assistance and consultation to Systems of Care as they develop family leadership and support groups. Rainbows is the family group for the Dawn Project, a nine year old, formerly Federally-funded SOC. Rainbows co-sponsored the sixth annual statewide Systems of Care annual conference. Twenty-five percent of conference participants were family members. Family members presented 40% of the workshops during the two day conference. Rainbows collaborates with the Technical Assistance Center in their regional trainings. They offer on-site consultation to newly forming family support groups. Consultation with Rainbows is a payment point for all state funded SOCs (currently 9

sites). Rainbows hosts a website and an active list serve. The Executive Director is Chair of the Transformation Work Group subcommittee on Consumer and Family Involvement.

The "**Consumer Mental Health Treatment Satisfaction Survey Results Report**," SFY 2004 provides the most recent information about parental appraisals of services received. The annual report provides information received from a telephone survey of family members of children. The survey instrument, the Youth Services Survey for Families, asks questions about access, participation, rights and satisfaction with services. The report offers youth and their families' information about mental health services that can help them determine the services they may select. . We anticipate publication of the 2005 survey by late 2006.

System Transformation:
In Oct., 2005 Indiana embarked on a movement to transform the state's mental health system. A core group of state legislators, agency heads, consumers, family members, providers and researchers formed the Transformation Workgroup for the purpose of achieving: a consumer centric system of planning, delivery and evaluation, alignment of systems, services, funding and technology, crafting a state role focused on leadership, not direct service, using results to inform quality improvement, knowledge dissemination to move science to service as efficiently as possible. Specific initiatives were launched in support to the transformation movement: consumer and family involvement, relationship management (to improve common understandings, metrics and deliverables between providers and DMHA), results management (measuring outcome of collective efforts), and cross-agency initiatives. As an immediate means to move toward transformation, DMHA instituted the **Consumer Services Review** process which began in May, 2006 and will conclude its initial review process of all 31 CMHCs when 300 cases have been reviewed by the end of 2006. The CSR focuses on practice and results. A sampling of the results are: services in the context of the life of a consumer, understanding of needs and personal recovery goals, responsiveness of the individual service plan, results and benefits of services for the person; successes and; missed opportunities.

DMHA is represented on the Governor's Interagency Coordinating Council for Infants and Toddlers (First Steps), the Head Start State Panel and Transition Planning Task Force of the Office of Vocational Rehabilitation and Department of Education. DMHA contributes a monthly newsletter column for all Head Start providers. DMHA staff is an active participant with the Indiana Council of Community Mental Health Centers Child and Adolescent Consortium. Staff serves as Principal Investigator for the Circle Around Families Federal grant site and on the Executive Committee of the Dawn Project, both of which are graduated Federal grant sites. DMHA also serves on the Department of Child Services Endangered Child Protocol Development Task Force and the Children's Social, Emotional and Behavioral Health Plan group. DMHA staff serves on the DOE's Student Assistance Program's Advisory, as well as the state Advisory to IDEIA. Staff offers regular consultation to the Juvenile Judges Quality Improvement Committee, as well as to Community Corrections in program development and implementation.

Strengths and Achievements

- Community Mental Health Centers and other providers offer a **range of services** for children. Indiana Administrative Code defines the population to be served, the continuum of care and sets service standards. The continuum includes case management, outpatient services, medication evaluation and monitoring, and family support. Contracts with providers assure Indiana children have access to mental health and addiction services anywhere in the state.
- Over 2/3 of the state's counties have developed or are developing a children's **System of Care**.
- The **1915(c) waiver** offers community-based care to children who would otherwise be admitted to a state hospital. Since its inception, it has served forty-three children and their families, with 35 children being diverted from hospitalization and eight youth returning to their communities from the state hospital.
- Strong cross-systems collaborations have resulted in the **Early Identification and Intervention** statewide initiative. Now in its second year, the Initiative has screened over 6,000 children and youth. Preliminary evaluation data shows that children entering the system are now receiving behavior health service at an earlier age than they would have prior to the screening.
- The adoption of a comprehensive assessment process, the **CANS** which will be implemented by DMHA in SFY 2008. All other child serving agencies are considering its adoption, which will establish algorithms for level of care, system level outcomes, and quality management processes. The Department of Correction intends to begin using the CANS in October, 2006.
- The 2005 legislature mandated the development of a comprehensive **children's social, emotional and behavior health plan** to be developed by June 2006. Written by a workgroup from the Department of Education, a family representative, Department of Child Services, Department of Corrections, State Department of Health, Office of Medicaid Policy and Planning and Division of Mental Health and Addiction, the plan objectives were: a focus on agency coordination, early identification and intervention, funding that assures access and equity, improved processes to deliver appropriate care to learn about effective practices and public education about resources and to reduce stigma. Public forums, state and national consultation were utilized in the creation of the plan. The Plan is under review by the state Board of Education, and expected to be forwarded to the legislature for its consideration.(See Attachment xx)
- During the writing of the Children's Plan and with Transformation activities, there has been an improvement in **collaboration among children's disability groups**. Lead by SED family groups, an umbrella organization, named *Natural Resource,* has developed. The group serves advocacy and policy-development needs.
- The DMHA **data system** has become more accessible to staff and providers, and is used more often in decision-making
- The **Consumer Services Review** process has involved DMHA staff, providers (at all levels) and family/consumers in the design of the review, as well as evaluation of the pilot. Additional stakeholders were trained in the process as they became reviewers. All providers will have been reviewed by year-end. The CSR process will become a platform for not only quality improvement but also a means to integrate recovery-based thinking/planning into provider work.

- The multi-level commitment to **develop effective models of care**

Challenges

- We continue to serve more children, despite no additional funding.
- In FY 2005, 76% of children served were covered by Medicaid at the time of enrollment, 16% had some other form of health insurance, and 5% were uninsured. Since private insurance coverage tends to be very limited, there exists a significant gap in coverage which providers must either fund or decline to provide. As more children enter the system with Medicaid funding, fewer dollars are available for services to non-Medicaid and/or indigent children.
- Data indicates providers are serving more children with high to moderate functioning, as opposed to those who are low functioning.
- Sustainability of many Systems of Care is being compromised by a shift in funding priorities by DCS.
- In SFY 2005 Medicaid spent over $145 million on children's mental health services (excluding psychotropic medications). Of this amount 20% was expended for residential/inpatient care with 80% expended for community services. Of concern for DMHA, approximately 55% of the residential/inpatient expenditures paid for Psychiatric Residential Treatment Facilities which are not part of the DMHA system. DMHA has been concerned about the growth of these facilities over the past three years and has started working with the Office of Medicaid Policy and Planning to further examine the utilization patterns and post-discharge services related to the youth being served in the facilities.

Unmet needs/gaps

- Based on estimated prevalence rates, for the designated DMHA child population (at or below 200% of federal poverty level), up to 10,000 youth may not be receiving services. (The actual number not receiving services is unknown as many children do receive some level of service from primary care and other providers not in the public mental health system.)
- With implementation of the Home and Community-based waiver, we have been challenged to develop the necessary community supports to fully support the waiver or expand community-care options throughout the state. There are few acute care resources for children in crisis. Often the juvenile justice system is inappropriately used as a resource. Indiana does not have adequate respite resources for families living with a youth/child with SED.
- There are an insufficient number of mental health professionals who are trained to assess and treat younger children. Indiana does not have a sufficient number of child psychiatrists. Few mental health professionals are trained to concurrently address both mental health and substance use disorders. Nationally, Indiana ranks 43rd in psychiatrists per capita, and 26th and 24th for psychologists and social workers per capita.
- The following special needs/populations are not well-served by the public mental health system: transitioning youth (to adult services, from institutions, etc.),

traumatized children/youth, substance abuse integrated into mental health needs, sexual offending youth, school-based mental health/comprehensive, tiered approach offered in schools.

Criterion 2
Mental Health System Data Epidemiology

State Definition of SED

In Indiana the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of SED is as follows:

The child has a mental illness diagnosis under DSM IV.

The child experiences significant functional impairments in at least one of the following areas:

Activities of daily living,
Interpersonal functioning,
Concentration, persistence and pace,
Adaptation to change

The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

This definition closely parallels the federal definition of serious emotional disturbance and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of children aged 9 through 17 with Serious Emotional Disturbance in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level. DMHA does not attempt to estimate the prevalence of children with SED for those younger than age 9 since there are no national studies that have included these very young children. Children aged birth through age 8 comprise 29% of the children receiving public mental health services in Indiana. Both calculations are provided in Section III.

Strengths/weaknesses

- The Hoosier Assurance Plan (HAP) directs public funding to those individuals in greatest need of mental health services. HAP is designed to equalize the availability and quality of community-based mental health and addiction treatment with an individualized array of services.
- During state funding year 2006, approximately 65% of children aged 9-17 and estimated to be in need of and eligible for state-funded services (living in families earning less than 200% of the Federal poverty level), received public mental health

services. Given diminished funding, this is a strength because it demonstrates that providers are serving children for whom they do not receive DMHA reimbursement. It is also a challenge, because there are more children needing services who do not receive them.

Criterion 3:
Children's Services

The Family and Social Services Administration's Division of Mental Health and Addiction (DMHA**)** is the state mental health authority. The Division advocates for the needs of persons in the target populations; establishes policy for funding and evaluation of community-based mental health and addiction treatment providers; establishes policy for and funding of a system of substance abuse prevention projects; establishes rules for the regulation of mental health providers; and currently operates a system of state psychiatric hospitals.

During FY 2007 DMHA will allocate block grant dollars in accordance with requirements identified in Section 1911. Stipulations are written in the contracts of each certified and approved provider of SED services.

The entire state is identified as the geographic region for block grant coverage. The identified service areas of the 25 providers of children's services cover all of Indiana's 92 counties.

Substance Abuse Services
Approved providers for SED children are required to offer substance abuse counseling and treatment for children dually diagnosed with SED and substance use and addiction. They must also assess the need for mental health services, and if appropriate, make referral for such services. In concert with various provider groups, we are exploring best practices in integrating substance abuse/mental health services for adolescents. SAMHSA has presented compelling research about more effective ways to treat dually diagnosed youth, which has been disseminated through several conference presentations.

Comprehensive Community Based Care Development
The Division partners with many state and local agencies that serve children. It encourages providers with whom it contracts to expand mental health services to children and families who are referred from child welfare, the schools, the juvenile courts and others. State mental health legislation that identifies continuum of care services puts a focus on services being provided in the community.

The **Office of Medicaid Planning and Policy (OMPP**) support primary medical, mental health services and dental services for eligible children. Through OMPP, DMHA has been successful in securing a 1915(c) Home and Community-based Waiver for children enabling SED youth to have the option of community-based care rather than

hospitalization. OMPP also supports Psychiatric Residential Treatment Facilities for Medicaid eligible children.

The **Indiana Department of Education**, through its Division of Exceptional Learners, has committed financial support of the waiver for a limited number of children under its auspices. The Division of Special Learners was assigned leadership in the development of the Children's Comprehensive Social, Emotional and Behavioral Health Plan. Through their participation in the Cross-Systems Team they have assisted in the planning and implementation of the Early Identification and Intervention initiative (referred to as the child welfare screening).

The **Indiana Department of Child Services (DCS**), in addition to provision of programs mentioned in Criteria I, is the pivotal participant in the child welfare screening, assessment and treatment initiative. With assistance from DMHA they have incorporated early childhood mental health information into the training for all new DCS workers, and have required early childhood mental health development training for foster parents.

Juvenile Justice Services are carried out through separate systems: county juvenile courts, county probation offices, 25 county-based detention centers and the Department of Correction, for incarcerated youth. There is no single Juvenile Justice authority in Indiana. The **Department of Correction (DOC**) offers some mental health programs, as well as community reintegration pilots. DMHA partners with Community Corrections in the development of new programs. Juvenile Courts and probation departments provide diversion and treatment programs. Detention Centers contract with mental health service providers. DMHA has developed partnerships with several entities with juvenile justice responsibilities. DOC has provided fiscal support for the state match for the HCBS 1915(c) waiver. They are partners on the Cross-System Team.

Strengths/weaknesses: Indiana has been very successful in forging productive partnerships among child serving agencies. We have been able to “get people to the table” through common values and visions. These significant initiatives are the result of several years’ work. The state’s goal to bring all child serving entities together in a consolidated “forum” that frames a comprehensive plan for our children has been addressed through the publication of the Children’s Social, Emotional and Behavioral Health Plan, which is now under review by the State Board of Education prior to presentation to the legislature.

Challenges: Our collaborators and partners are limited in the financial resources they can bring to the table. Implementation of the HCBS waiver has required considerable effort and focus. Indiana lacks a sufficient number of providers for the specialized waiver services.

Criterion 4
Services to Rural and Homeless Populations

Description of Homeless Population and Available Services

The definition of homelessness is persons who have no fixed address. They may live on the street, in a car or an abandoned structure. They may also be living in a shelter, living with family or friends under crowded or stressful conditions, living in deteriorated and unsafe housing often without utilities, or involved in support programs without which there would be a high risk of homelessness.

In November 2005, DMHA participated in the Policy Academy for Improving Access to Mainstream Services for Families and Children Experiencing Homelessness. The Indiana Housing and Community Development Agency provided state leadership for this Policy Academy. Other state participants included the Department of Education, Department of Correction, Office of Medicaid Policy and Planning, Indiana State Department of Health, Indiana Coalition on Housing and Homeless Issues, and four providers of homeless services for families. Indiana previously participated in a 2003 Policy Academy focused on chronic homelessness. Several of the 2005 participants are also involved in the state plan to end chronic homelessness which grew out of the 2003 Policy Academy.

Local mental health providers offer outreach services to children and families who are homeless. Services include crisis intervention, involvement with the homeless shelters in the community and supervised group living residential arrangements.

Definition of Rural and Description of Service Barriers

The Indiana definition of rural is "any county with a population of 100 persons per square mile or less." Sixty-three (63) of Indiana's 92 counties meet the definition of rural. The estimated 2005 census shows a total state population of 6,273,130 persons. There are 2,128,463 persons (34%) who live in rural counties.

The Division contracts with 25 providers for services to children with SED. One of these providers serves only rural counties. Nineteen providers serve a mix of rural/urban, and four serve only urban counties. Thirty-four (34) percent of all children and adolescents reported served by providers reside in the 63 rural counties of Indiana.

Strengths

We are serving an appropriate number of rural youth. Although the numbers are small, we have increased the number of homeless youth served from 2005 to 2006 by 30%.

The Division employs blended funding as it administers both state and federal funds to pay for services for children eligible for the Hoosier Assurance Plan. The state contract for both child and adult populations contains state general revenue funds and federal mental health block grant dollars. Even though these dollars are "blended" there remains a detailed accounting of the various sources for auditing purposes.

Role of the Mental Health Block Grant Program in Indiana

The mental health block grant plays an important role in funding services for children and youth with SED. At least ninety-five (95) percent the federal award is passed along to

providers as a portion of their state contract, with funding also going to support the family support and leadership technical assistance award to Families Reaching for Rainbows. The remainder is designated for administrative costs.

Block grant funds are used to pay for enrollments into the Community Mental Health System. At the time of contracting we are unable to project which providers will need to use block grant funds. Each provider contract states the limitations of block grant expenditures. DMHA funds are used to pay for services such as: individualized treatment planning, case management, outpatient, day treatment, and family support. The Division maintains specific accounting procedures for allocation of these dollars.

Allocation of Block Grant Funds

The Block Grant allocation to a provider is dependent on the rate at which that provider uses funds. Provider contracts specify the expenditure of Block Grant funds for treatment, according to the rules contained in PL 102-321. At the end of a fiscal year we know exactly how much each provider received from DMHA mental health block grant funds. The annual Block Grant Implementation Report includes a table showing the expenditures of funds by each provider. This table has had as few as eight providers and as many as thirty.

Emergency Health Providers

The DMHA Office of Emergency Management and Preparedness has developed short-term interventions with individuals and groups experiencing psychological responses to large-scale disasters. As collaborators with the Indiana State Department of Health, 75 mental health professionals have participated in extensive training, and are available to be deployed to state or national disasters. Ten regions within the state will train mental health responders to be available for local needs.

Strengths

The process of distributing money to providers assures that those dollars are used to serve children.

The DMHA Office of Emergency Management and Preparedness has incorporated learning from their work with the Katrina disaster into state planning, and has developed an extensive bank of resources to respond to future disasters and terrorism.

Weaknesses

The amount provided for a child enrollment in HAP is insufficient for even moderate courses of treatment. The lump sum distribution may discourage treatment beyond the intake stages and encourage enrollment of higher functioning youth (as opposed to those who may have greater need.).

Mental Health Planning Council Issues/Recommendations:

1. Explore ways to address needs of **transitional youth**: those moving from children's services into adult services, youth transitioning back into the community from hospitals, treatment facilities. An implementation plan should be considered.

2. There is a significant need for **acute care and crisis intervention** services to avoid unnecessary placements in detention centers, residential programs and/or misuse of emergency rooms.
   - As the use of the CANS assessment proceeds, level of care needs will be identified and tracked. This information will be used to identify gaps/need for services. When this data is aggregated it can be used in policy, financing and practice arenas.
   - As community-based care philosophy becomes accepted it is more likely that those critical resources may be developed.
   - Revision of the state's **Medicaid plan** should be considered.
   -
3. **Workforce issues**: there are very few providers who are equipped to asses or treat young children with mental health issues. This has created extensive waiting lists for these services.
   - DMHA has contracted with Indiana Infant and Toddler Mental Health Association to deliver trainings for DCS workers, foster parents and CMHC staff. However, this contract is not sufficient to meet the need.

SECTION III (CHILD AND ADOLESCENT)

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

(Note: All performance indicators for Children's Services are listed as Criterion 3. A cross-reference for Criteria 1, 2, 4, and 5 is noted where appropriate in the text below.)

CRITERION 3 (National Outcome Measures)

Goal A: Maintain the number of children and youth with SED served by DMHA providers.
Target: Maintain current level of services.
Population: Children/adolescents with serious emotional disturbances.
Criterion: Children's Services (Criterion 2: Mental Health System Data Epidemiology).
Brief name: ***Access***
Indicator: The number of unduplicated children with SED that are enrolled in mental health services during the fiscal year by age, gender, race/ethnicity.
Measure: Numerator: Number of children with SED enrolled during the fiscal year.
Denominator: None
Source of information: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.
Special Issues: Enrollment in the database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of person served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.
Significance: Assuring access to service is one of the major responsibilities of the state mental health authority.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: *Access*	**FY 2004 Actual**	**FY2005 Actual**	**FY 2006 Projected**	**FY 2007 Target**	**FY 2007 Attain**
Number Enrolled	24,513	29,598	27,000	29,000	
0- 3	677	698	700		
4 – 12	15,593	17,107	17,100		
13 - 17	8,243	9,164	9,200		

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator Access	**FY 2004 Actual**	**FY 2005 Actual**	**FY2006 Projected**	**FY 2007 Target**	**FY 2007 Attain**
Gender	24,513	26,969	27,000	29,000	
Male	14,896	16,379			
Female	9,617	10,590			
Race/Ethnicity	24,513	26,969	27,000	29,000	
American Indiana or Alaska Native	89	106			
Asian	66	35			
Black or African-American	4,499	4,983			
Native Hawaiian or other Pacific Islander	8	12			
White	18,121	19,785			
More than one Race	946	1,267			
Race Not Available	784	781			
Hispanic	1,224	1,424			

Goal B: Children and adolescents with serious emotional disturbance will receive appropriate and comprehensive community-based services.

Target: To maintain current levels of readmission to state psychiatric hospitals at 30 days and 180 days post discharge.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Reduced Utilization of Psychiatric Inpatient Beds***

Indicator: The number of persons aged 17 and under who are discharged from a state psychiatric hospital during the fiscal year who are re-admitted to a state psychiatric hospital within 30 days and within 180 days.

Measure: Numerator: Number of persons, aged 17 and under, who are readmitted to a State hospital within 30 days and within 180 days.
Denominator: None.

Sources of Information: The state hospitals maintain a database that is separate from the community services database. Information about admission and discharge is contained in that database for each individual served.

Special Issues: The state psychiatric hospitals are medium- to long-term care facilities. Therefore, the number children/adolescents readmitted at 30 days is expected to be quite low. The 180 days readmission also tends to be quite low. Both of these measures are used by the state psychiatric hospital system to monitor quality.

Significance: This measure monitors the effectiveness of community services for children and adolescents who have been discharged from state psychiatric hospitals. As Indiana proceeds to localize (privatize) state psychiatric hospitals, monitoring both 30 day and 180 day readmissions will become an essential quality indicator for both community and hospital services.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***Reduced Utilization of Psychiatric Inpatient Beds***	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Readmitted at 30 days	n/a	1	1	1	---
Readmitted at 180 days	n/a	4	4	2	---

Goal C: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Target: To increase the number of evidence-based practices provided by the community mental health system.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Evidence-Based Practices Provided***

Indicator: The number of evidence-based practices being provided in the state.

Measure: Numerator: For Therapeutic Foster Care indicate (Yes-No) whether it is being provided.
Denominator: None

Sources of Information: Therapeutic Foster Care is available in the State; however, it is primarily provided through the Department of Child Services (child welfare) and is not available to all children or managed by the state mental health authority. Three community mental health providers also report that they provide Therapeutic Foster Care and maintain encounter level data for their service.

Special Issues: Rather than require evidence-based practices by providers, Indiana has chosen to engage in a process to surface effective practices, improve and disseminate them through the resources of the Technical Assistance Center. The TAC provides information, consultation and training to communities and states working to identify, implement and evaluate evidence-based practices. They work with communities on assessing their readiness for change and to build on existing effective practices to promote social, emotional and behavioral health for children and their

families. Through this resource, and approach, communities will be able to measure their fidelity to identified practice modes, undertake outcome management, and receive coaching on the implementation process. As fidelity and outcome data are collected on a wide variety of services delivered throughout Indiana, effective models of care will quickly emerge. These models will be shared and implemented in other communities, according to their communities unique needs.

Significance: None. It is not clear that an evidence-based practice model is actually being implemented or that the practice is consistent across the state.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***EBP Provided (Y or N)***	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Therapeutic Foster Care Provided	Y	Y	Y	Y	

Goal D: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Target: To increase the number of children receiving Therapeutic Foster Care.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Evidence-Based Practices Provided (TFC)***

Indicator: The number of children receiving Therapeutic Foster Care through the community mental health system.

Measure: Numerator: Number of children aged 0 – 17 who receive TFC provided by a mental health provider under contract with the SMHA during the year.
Denominator: None

Sources of Information: Three mental health providers under contract with the SMHA offer Therapeutic Foster Care in the State. Data is submitted by the providers to the state database (CSDS) encounter system.

Special Issues: Other TFC is provided throughout the state by the child welfare agency. Of the total number of children served by the mental health system who are living in a therapeutic foster care setting, more than 65% are being served by one of the three mental health providers.

Significance: None. It is not clear that an evidence-based practice model is actually being implemented.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***EBP Provided (TFC)***	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Number Served by mental health system	467	559	550	550	
Number Served outside the mental health system	210	271	250	250	

Goal E: Family caretakers of child and adolescent **c**onsumers will report positively about outcomes.

Targets: To increase the number of family caretakers reporting positively about outcomes.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Client Perception of Care***

Indicator: The percentage of family caretakers reporting positively about outcomes through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the outcome domain on the child and family survey.
Denominator: Total responses reported in the outcome domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family's positive perception of the outcomes derived from the treatment services received by their child and themselves is necessary to stay with services until their goals are attained. The 2005 survey data will be available by the 2006 Implementation report.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Family Perception of Care***	69/7%	NA	70%	75%	
Numerator	1,380				
Denominator	1,981				

CRITERION 3 (State Level Measures)

Goal F: To provide case management services for all children and adolescents with serious emotional disturbance who are receiving services through the public mental health system and who are in need of these services.

Target: To increase by one percent the percent of number of children/adolescents with serious emotional disturbance who receive case management.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Percentage receiving case management***.

Indicator: Percentage of children/adolescents with serious emotional disturbance who receive case management services among those who receive public mental health services.

Measure: Numerator: The number of child/adolescent consumers with a serious emotional disturbance who are receiving case management services during the fiscal year.

Denominator: The number of child/adolescent consumers with a serious emotional disturbance who receive public mental health services during the fiscal year.

Sources of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.

Special Issues: None.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Case Management***	76%	78%	77%	78%	
Numerator	19,196	22,674		---	---
Denominator	25,369	28,257	27,000	29,000---	---

Goal G: Family caretakers of child and adolescent **c**onsumers will report that they are satisfied with access to services.

Targets: To maintain the number of families reporting satisfaction with access to services each year.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Satisfaction with Access***

Indicator: The percentage of families reporting positively about satisfaction with access through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the access domain on the child and family survey.
Denominator: Total responses reported in the access domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family's satisfaction with access to the treatment services received by their child and themselves is necessary to stay with services until their goals are attained. Data from the 2005 Consumer Survey will be available for the 2006 Implementation report.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Overall Satisfaction***	92%	%	80%	80%	
Numerator	1,380				
Denominator	1,981				

Goal H: Family caretakers of child and adolescent **c**onsumers will report that the services were provided in a manner that was sensitive to the family's culture.

Targets: To maintain the number of families reporting that the services were provided in a manner that was sensitive to the family's culture each year.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Cultural Sensitivity***

Indicator: The percentage of families reporting positively about satisfaction with the cultural sensitivity of services through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the cultural sensitivity domain on the child and family survey.
Denominator: Total responses reported in the cultural sensitivity domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family perception that the services and providers are respectful of, understanding of, and accommodating to their culture is necessary to stay with services until their goals are attained. Results of the 2005 Consumer Survey will be avaialabe for the 2006 Implementation Report.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator: ***Cultural Sensitivity***	92.2%		92%	93%	
Numerator	1,692				
Denominator	1,836				

Goal I: Increase the number of children enrolled in Systems of Care.
Targets: The number of children enrolled in Systems of Care will increase by 5% each year.
Population: Children diagnosed as seriously emotionally disturbed.
Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).
Brief name: ***Systems of Care***
Indicator: The number of children enrolled in Systems of Care in the community mental health system
Measure: Numerator: Number of children enrolled in Systems of Care
Denominator: None
Sources of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.
Special Issues: There continues to be errors in SOC enrollments. Some providers mistakenly enter children as enrolled, while others do not report children who are enrolled. We continue to work directly with providers as they improve their reporting.
Significance: Systems of Care is an effective approach to address the complex needs of SED children and their families. However, during SFY 2007 it is anticipated there will be significant funding challenges for many of the state's Systems of Care, as the Department of Child Services redefines its funding priorities. The DCS has been a significant funding partner for many of the SOCs.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Systems of Care enrollment***	723 2.6%	949 3.2%	900	900	
Numerator	723	949	900		
Denominator	25,396	28,257			

Goal J: Maintain the number of children and youth with SED served by DMHA providers.
Target: Maintain current level of services.
Population: Children/adolescents with serious emotional disturbances.
Criterion: Children's Services (Criterion 2: Mental Health System Data Epidemiology).
Brief name: ***Penetration Rate***
Indicator: The number of unduplicated persons with SED that are enrolled in mental health services during the fiscal year

Measure: Number and percent of enrolled children/youth compared with the prevalence rate for Indiana SED
Numerator: Number of children with SED enrolled during the fiscal year.
Denominator: The number of Indiana children estimated to live in families with income at or below 200% of poverty level and who are estimated to be in need of services

Source of information: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service. Indiana Prevalence Reports based on the 2000 United States Census.

Special Issues: Enrollment in the database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may by under-reporting actual numbers of person served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to service is one of the major responsibilities of the state mental health authority.

Performance Indicator Table

(1)	**(2)**	(3)	(4)	(5)	(6)
Fiscal Year	FY 2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 Attain
Performance Indicator: ***Penetration***	80%	91%	78%	85%	
Numerator	25,369	28,257			
Denominator	31,639	31,639	31,639		

Goal k: Maintain the level of services to children living in rural areas of the state.

Target: To maintain number of children living in rural areas who receive community-based mental health services.

Population: Children with serious emotional disturbances.

Criterion: Children's Services (Criterion 4: Targeted Services to Rural and Homeless Population).

Brief name: ***Rural services***

Indicator: Number of rural SED children/youth receiving services.

Measure: Numerator: Number of rural youth receiving services.
Denominator: None

Source(s) of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers.

Special Issues: Over 68 % of Indiana's counties are rural with slightly over 71% of the population aged 0 – 17 living in urban counties. Of the children/

adolescents served by the public mental health system, approximately 70% live in urban counties and 30% live in rural counties.

Significance: Services should be equally accessible whether the child/adolescent resides in a rural area or an urban area.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Rural***	7,846	8,585	8,300	8,500	
Numerator	7,846	8,585	8,300	8,500	
Denominator	25,398	28,257			

Goal M: Maintain funding from state and federal sources for mental health services for children

Target: To maintain adequate funding to support services for children's mental health

Population: Children with serious emotional disturbances served in the public mental health system

Criterion: Children's Services (Criterion 5: Management Systems).

Brief name: ***DMHA Children's Funding***

Indicator: The amount of DMHA funds expended for children/adolescents with SED

Measure: Numerator: The amount of DMHA funds expended for children with serious emotional disturbances
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target	FY 2007 % attain
Performance Indicator ***Children's Funding***	$14 M	$13 M	$14 M	$14 M	
Numerator	$14 M	$14 M	$14 M	$14 M	